A bill for an act

relating to health care; modifying the general assistance medical care program; appropriating money; amending Minnesota Statutes 2008, sections 256.9657, subdivisions 2, 3; 256.969, subdivision 27, by adding a subdivision; 256B.69, by adding a subdivision; 256L.05, subdivision 3; 256L.07, subdivision 6; 256L.15, subdivision 4; proposing coding for new law in Minnesota Statutes, chapter 256D.

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

Section 1. Minnesota Statutes 2008, section 256.9657, subdivision 2, is amended to read:

Subd. 2. **Hospital surcharge.** (a) Effective October 1, 1992, each Minnesota hospital except facilities of the federal Indian Health Service and regional treatment centers shall pay to the medical assistance account a surcharge equal to 1.4 percent of net patient revenues excluding net Medicare revenues reported by that provider to the health care cost information system according to the schedule in subdivision 4.

(b) Effective July 1, 1994, the surcharge under paragraph (a) is increased to 1.56 percent.

(c) Effective March 1, 2010, to June 30, 2011, the surcharge under paragraph (b) is increased to 4.97 percent. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (b) shall be deposited in the account established in section 256D.032.

(d) Notwithstanding the Medicare cost finding and allowable cost principles, the hospital surcharge is not an allowable cost for purposes of rate setting under sections 256.9685 to 256.9695.

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

Sec. 2. Minnesota Statutes 2008, section 256.9657, subdivision 3, is amended to read:

Subd. 3. **Surcharge on HMOs and community integrated service networks.** (a) Effective October 1, 1992, each health maintenance organization with a certificate of authority issued by the commissioner of health under chapter 62D and each community integrated service network licensed by the commissioner under chapter 62N shall pay to the commissioner of human services a surcharge equal to six-tenths of one percent of the total premium revenues of the health maintenance organization or community integrated service network as reported to the commissioner of health according to the schedule in subdivision 4.

(b) Effective March 1, 2010, to June 30, 2011, the surcharge under paragraph (a) is increased to ... percent. Notwithstanding section 256.9656, money collected under this paragraph in excess of the amount collected under paragraph (a) shall be deposited in the account established in section 256D.032.

(c) For purposes of this subdivision, total premium revenue means:

(1) premium revenue recognized on a prepaid basis from individuals and groups for provision of a specified range of health services over a defined period of time which is normally one month, excluding premiums paid to a health maintenance organization or community integrated service network from the Federal Employees Health Benefit Program;

(2) premiums from Medicare wrap-around subscribers for health benefits which supplement Medicare coverage;

(3) Medicare revenue, as a result of an arrangement between a health maintenance organization or a community integrated service network and the Centers for Medicare and Medicaid Services of the federal Department of Health and Human Services, for services to a Medicare beneficiary, excluding Medicare revenue that states are prohibited from taxing under sections 1854, 1860D-12, and 1876 of title XVIII of the federal Social Security Act, codified as United States Code, title 42, sections 1395mm, 1395w-112, and 1395w-24, respectively, as they may be amended from time to time; and

(4) medical assistance revenue, as a result of an arrangement between a health maintenance organization or community integrated service network and a Medicaid state agency, for services to a medical assistance beneficiary.

If advance payments are made under clause (1) or (2) to the health maintenance organization or community integrated service network for more than one reporting period, the portion of the payment that has not yet been earned must be treated as a liability.

~~(c)~~ (d) When a health maintenance organization or community integrated service network merges or consolidates with or is acquired by another health maintenance

organization or community integrated service network, the surviving corporation or the new corporation shall be responsible for the annual surcharge originally imposed on each of the entities or corporations subject to the merger, consolidation, or acquisition, regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(d)~~ (e) Effective July 1 of each year, the surviving corporation's or the new corporation's surcharge shall be based on the revenues earned in the second previous calendar year by all of the entities or corporations subject to the merger, consolidation, or acquisition regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N until the total premium revenues of the surviving corporation include the total premium revenues of all the merged entities as reported to the commissioner of health.

~~(e)~~ (f) When a health maintenance organization or community integrated service network, which is subject to liability for the surcharge under this chapter, transfers, assigns, sells, leases, or disposes of all or substantially all of its property or assets, liability for the surcharge imposed by this chapter is imposed on the transferee, assignee, or buyer of the health maintenance organization or community integrated service network.

~~(f)~~ (g) In the event a health maintenance organization or community integrated service network converts its licensure to a different type of entity subject to liability for the surcharge under this chapter, but survives in the same or substantially similar form, the surviving entity remains liable for the surcharge regardless of whether one of the entities or corporations does not retain a certificate of authority under chapter 62D or a license under chapter 62N.

~~(g)~~ (h) The surcharge assessed to a health maintenance organization or community integrated service network ends when the entity ceases providing services for premiums and the cessation is not connected with a merger, consolidation, acquisition, or conversion.

EFFECTIVE DATE. This section is effective March 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. 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, 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 March 1, 2010, to June 30, 2011, the amount of the three percent ratable reduction required under this paragraph shall be deposited in the account established in section 256D.032.

(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, 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, adjust, on a pro rata basis if feasible, the amounts reported by nonstate entities under section 256B.199 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 and payments under this section.

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

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

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

Subd. 31. **Temporary rate increase.** For admissions occurring effective March 1, 2010, to June 30, 2011, payment rates under this section shall be increased by ... percent. This increase shall be paid from the account established in section 256D.032. For purposes of this subdivision, medical assistance does not include general assistance medical care.

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

Sec. 5. Minnesota Statutes 2008, section 256B.69, is amended by adding a subdivision to read:

Subd. 5k. **Temporary rate modifications.** For services rendered effective March 1, 2010, to June 30, 2011, the total payment made to managed care plans under the medical assistance program shall be:

(1) increased by ... percent. This increase shall be paid from the account established in section 256D.032; and

(2) reduced by ... percent. The savings from this payment reduction shall be deposited in the account established in section 256D.032.

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

Sec. 6. **[256D.031] TEMPORARY 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, or MinnesotaCare, except as provided in subdivision 3, 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 with dependent children under the age of 21;

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

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

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

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

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

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

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

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

Subd. 3. **Transitional MinnesotaCare.** (a) Except as provided in paragraph (c), effective March 1, 2010, all applicants and recipients who meet the eligibility requirements in subdivision 1, paragraph (a), clause (2), shall be enrolled in MinnesotaCare under section 256L.04, subdivision 7, immediately following approval of general assistance medical care if the applicant or recipient is determined to be eligible for MinnesotaCare.

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

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

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

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

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

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

(5) receives treatment funded in section 254B.02.

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

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

Subd. 4. **Eligibility and enrollment procedures.** (a) Eligibility for general assistance medical care shall begin no earlier than the date of application. The date of application shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an application by providing the county agency or Department of Human Services with provider identification and a temporary unique identifier for the applicant. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The applicant must complete the application within the time periods required under the medical assistance program as specified in Minnesota Rules, parts 9505.0015, subpart 5; and 9505.0090, subpart 2. The county agency must assist the applicant in obtaining verification if necessary.

(b) For individuals eligible under subdivision 1, paragraph (a), clause (1), a redetermination of eligibility must occur every 12 months. For individuals eligible under subdivision 1, paragraph (a), clause (2), a redetermination of eligibility must occur every six months.

(c) 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.

(d) In determining the amount of assets of an individual eligible under subdivision 1, paragraph (a), clause (1), 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.

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

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

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

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) 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.

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

(c) Drug coverage 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. 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.

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

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

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

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

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

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

Subd. 6. **Division of costs.** The state share of county expenditures for general assistance medical care shall be 90 percent. Payments made under this subdivision shall be made according to sections 256B.041, subdivision 5.

Subd. 7. **Accountable care organization county option.** (a) A county may elect to provide health care services to individuals who are eligible for general assistance medical care under this section and who reside within the county through an accountable care organization. Counties that elect to provide health care services through an accountable care organization must ensure that the accountable care organization meets the requirements of paragraph (c) and that the accountable care organization can provide all services described in subdivision 5 with the exception of outpatient prescription drug coverage.

(b) A county that elects to provide services through an accountable care organization must provide to the commissioner the following:

(1) the names of the county or counties that are electing to provide services through the accountable care organization;

(2) the geographic area served by the accountable care organization;

(3) sufficient information to establish that the accountable care organization has the operational capacity, facilities, and personnel to provide the covered services to recipients residing within the geographic area served by the accountable care organization;

(4) an outline indicating how the accountable care organization plans on coordinating 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

(5) any other information as required by the commissioner to ensure the delivery of quality care and consumer protection.

(c) An accountable care organization is not required to obtain a certificate of authority under chapter 62D. An accountable care organization must include primary care physicians, specialists, and at least one hospital, and may be administered by a managed care plan, a county-based purchasing plan, an integrated delivery system, a physician-hospital organization, or an academic health center. An accountable care organization must demonstrate the ability to:

(1) ensure that covered services are accessible to all general assistance medical care recipients residing with the geographic area served by the accountable care organization;

(2) provide a system for advocacy, consumer protection, and complaints and appeals that is independent of care providers or other risk bearers associated with the accountable care organization; and

(3) establish a process to ensure and improve the quality of care provided.

(d) The state shall not be liable for the payment of any cost or obligation incurred by the county, the accountable care organization, or a participating provider.

Subd. 8. **Limitation of choice.** (a) The commissioner may require a general assistance medical care recipient to receive their health care services through designated health care providers except in the case of an emergency. If a county elects to provide services through an accountable care organization, the county may require that recipients receive their health care through the accountable care organization, and the health care providers who are associated with the accountable care organization, unless authorized by the accountable care organization or in the case of an emergency.

(b) The commissioner or an accountable care organization may require a recipient to designate a primary care provider or a primary care clinic that has been certified as a health care home under section 256B.0751.

Subd. 9. **County allocation.** The commissioner shall determine for each county a general assistance medical care county allocation amount that equals the following:

(1) each county's total general assistance medical care per capita cost that was paid for all services with the exception of outpatient prescription drug coverage provided in fiscal year 2009 to general assistance medical care recipients residing within the county; and

(2) one-third of the county's total per capita cost described in clause (1).

Subd. 10. **Payments; fee-for-service rate for the period between March 1, 2010, and July 1, 2010.** (a) Effective for services provided on or after March 1, 2010, and before July 1, 2010, the payment rates for all covered services provided to general assistance medical care recipients, with the exception of outpatient prescription drug coverage, shall be 50 percent of the general assistance medical care payment rate in effect on February 28, 2010.

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

Subd. 11. **Payments; rate setting for accountable care organizations.** (a) Effective for services provided on or after July 1, 2010, and before July 1, 2011, to general assistance medical care recipients residing in counties that have elected to provide services through an accountable care organization, the commissioner shall establish a prospective fixed payment for each accountable care organization. The payment must not exceed 60 percent of the county's general assistance medical care allocation established in subdivision 9, clause (1).

(b) The commissioner may adjust this payment to an amount that ensures that the total payment for services excluding outpatient prescription drug coverage provided to the general assistance medical care recipients residing within the county served by the accountable care organization between March 1, 2010, and July 1, 2011, does not exceed 60 percent of the county's allocation established in subdivision 9.

Subd. 12. **Payments; fee-for-service rates.** (a) Effective for services provided on or after July 1, 2010, and before July 1, 2011, to general assistance medical care recipients residing in counties that are not served by an accountable care organization, payments shall be made by the commissioner to providers at rates described in this subdivision.

(b) For inpatient hospital services provided on or after July 1, 2010, and before July 1, 2011, that are provided by hospitals that received more than $..... in revenue from the general assistance medical care program in fiscal year 2009, there shall be no reimbursement for services provided until the total payments for services provided to general assistance medical care recipients by the hospital equals $1,000,000, calculated by using 50 percent of the general assistance medical care payment rate for the services

provided that is in effect on February 28, 2010. Upon reaching $1,000,000, the payment rate to the hospital shall be as follows: 50 percent of the rate in effect on February 28, 2010, up to the next $10,000 in costs, no payment for costs greater than $10,000 but not exceeding $20,000, and payments as established in paragraph (d) for costs greater than $20,000.

(c) For inpatient hospital services provided on or after March 1, 2010, and before July 1, 2011, that are provided by hospitals that received less than $..... in revenue from the general assistance medical care program in fiscal year 2009, there shall be no reimbursement for services provided until the total payments for services provided to general assistance medical care recipients by the hospital equals $500,000, calculated by using 50 percent of the general assistance medical care payment rate for the services provided that is in effect on February 28, 2010. Upon reaching $500,000, the payment rate to the hospital shall be as follows: 50 percent of the rate in effect on February 28, 2010, up to the next $10,000 in costs, no payment for costs greater than $10,000 but not exceeding $20,000, and payments as established in paragraph (d) for costs greater than $20,000.

(d) For all services other than outpatient prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011, the payment rate shall begin at 50 percent of the general assistance medical care rate in effect on February 28, 2010. For each county, the commissioner shall adjust on a quarterly basis the payment rates to be paid to providers for the services provided to residents of the county based on the total cost of services provided to the residents for the second previous quarter and the county's allocation amount established in subdivision 9. The payment rates to providers for services provided to recipients residing in the specific county shall be adjusted by a percentage that ensures that the total cost of the services provided does not exceed 50 percent of the county's allocation amount established in subdivision 9.

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

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

Sec. 7. **[256D.032] TEMPORARY MEDICAL CARE ACCOUNT.**

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

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

Sec. 8. 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~~ sections 256D.03, subdivision 3, or 256D.031 is the first day of the month following the last day of general assistance medical care coverage.

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

Sec. 9. Minnesota Statutes 2008, section 256L.07, subdivision 6, is amended to read:

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

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

Sec. 10. Minnesota Statutes 2008, section 256L.15, subdivision 4, is amended to read:

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

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

Sec. 11. **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 under Minnesota Statutes, section 256D.031, in accordance with Minnesota Statutes, section 256.01, subdivision 2, paragraph (cc). The rebate revenues collected under the drug rebate program for persons eligible for the general assistance medical care program shall be deposited in the temporary medical care account in the state government special revenue fund.

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

Sec. 12. **TEMPORARY SUSPENSION.**

For the period beginning March 1, 2010, to June 30, 2011, the commissioner of human services shall not implement or administer Minnesota Statutes 2008, section 256D.03, subdivisions 6 and 9; Minnesota Statutes 2009 Supplement, section 256D.03, subdivisions 3 and 4; or Minnesota Statutes 2008, section 256B.692; and Minnesota Statutes 2009 Supplement, section 256B.69, as they apply to the general assistance medical care program.

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

Sec. 13. **MENTAL HEALTH URGENT CARE AND PSYCHIATRIC CONSULTATION.**

Subdivision 1. **Mental health urgent care and psychiatric consultation.** The commissioner of human services shall include statewide mental health urgent care and psychiatric consultation services as part of 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. The redesign is a result of the governor's decisions to unallot a portion of the state operated services funding in order to balance the budget.

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

(a) Mental health urgent care includes:

(1) initial mental health screening;

(2) mobile crisis assessment and intervention;

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

(4) nonhospital crisis stabilization residential beds;

(5) necessary psychiatric prescriptions from a qualified individual and assistance in obtaining psychiatric medications; and

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

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

Sec. 14. **APPROPRIATION TRANSFER.**

Of the general fund appropriation to the commissioner of human services for health care management in Laws 2009, chapter 79, article 13, section 3, subdivision 7, as amended by Laws 2009, chapter 173, article 2, section 1, $..... for health care administration and $..... for health care operations shall be transferred on March 1, 2010, to the fund established in Minnesota Statutes, section 256D.032.

Sec. 15. **APPROPRIATIONS.**

The following appropriations are from the fund established in Minnesota Statutes, section 256D.032, to the commissioner of human services for the time periods and purposes indicated:

(1) $..... for the period from March 1, 2010, to June 30, 2010, and $..... for fiscal year 2011 for the hospital rate increase under Minnesota Statutes, section 256.969, subdivision 31;

(2) $..... for the period from March 1, 2010, to June 30, 2010, and $..... for fiscal year 2011 for the managed care plan rate increase in Minnesota Statutes, section 256B.69, subdivision 5k, clause (1); and

(3) $..... for the period from March 1, 2010, to June 30, 2010, and $..... for fiscal year 2011 for the temporary general assistance medical care program established in Minnesota Statutes, section 256D.031.