House Research Act Summary

CHAPTER: 182 (vetoed) **SESSION:** 2010 Regular Session

TOPIC: Temporary GAMC Program

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Overview

This act establishes a temporary General Assistance Medical Care (GAMC) program for the period March 1, 2010, through June 30, 2011. The act specifies eligibility criteria, covered services and payment rates, allows counties to provide services through a coordinated care delivery option, and makes changes in the delivery of certain mental health services. The act provides funding sources for GAMC and suspends certain provisions of current GAMC law.

Section

1 **Mental health urgent care and psychiatric consultation.** Adds § 245.4862.

Subd. 1. Mental health urgent care and psychiatric consultation. Requires the commissioner to 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 Anoka-Metro Regional Treatment Center. Requires these services to not duplicate existing services and to be implemented as specified in subdivisions 3 to 8.

Subd. 2. Definitions. Defines terms.

Subd. 3. Rapid access to psychiatry. Requires the commissioner to develop rapid access to psychiatric services and specifies criteria.

Subd. 4. Collaborative psychiatric consultation. Requires the commissioner to establish a collaborative psychiatric consultation service and specifies criteria.

Subd. 5. Phased availability. Allows the commissioner to 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. Requires the first phase of subdivisions 3 to 5 to focus on adults in Hennepin and Ramsey Counties and children statewide for whom collaborative psychiatric consultations and prior authorization are required under § 256B.0625, subdivision 13j.

Subd. 6. Limited appropriations. Requires the commissioner to maximize the use of available health coverage for the services provided under this section and specifies that the commissioner's responsibility to provide services for persons without health care coverage must not exceed the appropriation.

Subd. 7. Flexible implementation. Requires the commissioner to select the structure and funding method that is the most cost-effective for each county or group of counties. Directs the commissioner, where feasible, to make grants under this section a part of the integrated mental health initiative grants.

2 **Operating payment rates.** Amends § 256.969, subd. 2b. Extends by three months, until July 1, 2011, the time period during which hospital operating payment rates are not rebased. Beginning July 1, 2011, rebasing is at the current law phase-in value of 39.2 percent, with rebasing at full value occurring April 1, 2012, as provided under current law.

3 **Payments.** Amends § 256.969, subd. 3a. The amendment to paragraph (f) extends by one year, through June 30, 2011, a 1.9 percent reduction in inpatient hospital payment rates. The amendment to paragraph (g) makes a conforming change, delaying by one year, until July 1, 2011, the lowering of this reduction to 1.79 percent.

4 **Psychiatric and burn services payment adjustment on or after July 1, 2010.** Amends § 256.969, by adding subd. 26a. (a) For admissions occurring on or after July 1, 2010, requires the commissioner to increase MA payment rates for fee-for-service admissions for specified DRGs related to psychiatric and burn services, for any hospital that is a nonstate public Minnesota hospital and a level I trauma center. Requires the rates to be established at a level that uses each hospital's voluntary payments under paragraph (c) as the nonfederal share. Specifies that this provision does not apply to GAMC. Provides that payments to managed care plans shall not be increased for payments under this subdivision.

(b) Specifies the DRGs to which the rate increases apply.

(c) Requires Hennepin County to make a voluntary payment of $7 million, and Ramsey County a voluntary payment of $3.5 million, to the commissioner on an annual basis, as part of the governmental unit's portion of the nonfederal share of MA costs.

(d) Allows the commissioner to adjust the transfers and payments, based on a determination of Medicare upper payment limits, any federal local share limits, and hospital-specific charge limits.

(e) Provides that the section shall be implemented upon federal approval, retroactive to July 1, 2010.

5 **Quarterly payment adjustment.** Amends § 256.969, subdivision 27. Modifies language governing quarterly hospital payments. Excludes Hennepin County Medical Center and Regions Hospital from the payment adjustments. Under current law, these payments are reduced by an amount equivalent to a 3 percent reduction in MinnesotaCare and MA payments for inpatient hospital services. This savings accrues to the MA account in the general fund. This section provides that from March 1, 2010, to June 30, 2011, the money attributable to this ratable reduction is deposited in the general assistance medical care account and not in the general fund. Requires additional ratable reductions of $3.243 million in FY 2011 and $2.495 million in FY 2012, and requires these amounts to be deposited in the general assistance medical care account. States that this section is effective for services provided on or after March 1, 2010.

6 **Prior authorization.** Amends § 256B.0625, subd. 13f. Makes a conforming change. Provides a March 1, 2010, effective date.

7 **Antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications.** Amends § 256B.0625, by adding subd. 13j. (a) Requires the commissioner, in consultation with the Drug Utilization Review Board and actively practicing pediatric mental health professionals, to: (1) identify recommended pediatric dose ranges for atypical antipsychotic drugs and drugs used for attention deficit disorder or attention deficit hyperactivity disorder; (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; and (3) track prescriptive practices and use of psychotropic medications in children with the goal of reducing use of medication.

(b) Effective July 1, 2011, directs the commissioner to require authorization and a collaborative psychiatric consultation before atypical antipsychotic and attention deficit disorder and attention deficit hyperactivity disorder medications meeting the criteria identified in paragraph (a), clause (2), are eligible for payment. Provides an exception from this requirement and an alternative procedure when the patient is already stabilized on the medication regimen or the provider indicates that the child is in crisis.

(c) Requires a collaborative psychiatric consultation to meet the criteria in § 245.4862, subdivision 5.

8 **Commissioner's duties.** Amends § 256B.196, subd. 2. Expands the Hennepin and Ramsey County intergovernmental transfer to include all licensed health care plans, rather than just Metropolitan Health Plan and HealthPartners. Requires the commissioner to increase MA capitation payments to each health plan that makes payments to Hennepin County Medical Center or Regions Hospital by an amount equal to the value of the transfers plus federal participation.

9 **Payments reported by governmental entities.** Amends § 256B.199. The amendment to paragraph (b) eliminates the University of Minnesota and Fairview University Medical Center from the list of entities required to report certified public expenditures to the commissioner.

A new paragraph (e) requires Hennepin County to make a voluntary payment of $6.2 million and Ramsey County to make a voluntary payment of $4.0 million on an annual basis.

A new paragraph (f) provides that these payments are part of the governmental unit's portion of the nonfederal share of MA costs.

A new paragraph (g) requires the commissioner to make monthly Medicaid disproportionate share hospital payments to Hennepin County Medical Center and Regions Hospital using any federal funds available to match the payments in paragraph (e).

A new paragraph (h) requires payments in paragraph (g) to be made before payments for psychiatric and burn services.

A new paragraph (i) requires the payments in paragraphs (g) and (h) to be made prior to other payments in this section, the quarterly payment adjustments, and payments made through intergovernmental transfers under § 256B.195.

A new paragraph (j) allows the commissioner to adjust intergovernmental transfers under paragraph (e) and payments under paragraph (g) based upon upper payment limits, hospital-specific charge limits, and federal local share limits.

A new paragraph (k) provides that the section shall be implemented retroactive to July 15, 2010, upon federal approval of the rate increase and a federal determination that the increased transfers do not violate share limits.

10 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. States that the required transfer of certain GAMC enrollees to MinnesotaCare does not apply to enrollees exempt due to a GAMC qualifying status. Also prohibits the commissioner from requiring an enrollee with a GAMC qualifying status to enroll in MinnesotaCare. Provides that for the period March 1, 2010, through June 30, 2011, GAMC is to be administered according to § 256D.031. Provides a March 1, 2010, effective date.

11 **Claims; assignment of benefits.** Amends § 256D.03, subd. 3a. Effective for GAMC services provided between March 1, 2010, and June 30, 2011, requires third-party medical collections, payments, or recoveries from claims to be deposited in or credited to the general assistance medical care account. Provides a March 1, 2010 effective date.

12 **Cooperation.** Amends § 256D.03, subd. 3b. Effective for GAMC services provided between March 1, 2010, and June 30, 2011, requires third-party medical collections, payments, or recoveries resulting from recipient cooperation to be deposited in or credited to the general assistance medical care account. Provides a March 1, 2010 effective date.

13 **Enrollee characteristics; eligibility criteria.** Amends § 256D.03, by adding subd. 3c. Requires the commissioner to study the demographic characteristics, health care needs, and utilization of GAMC enrollees, and by December 15, 2010, identify the characteristics of enrollees who are single adults or in households without children who can be served more effectively under modified MinnesotaCare coverage. Requires the commissioner to establish eligibility criteria for modified MinnesotaCare coverage.

14 **General Assistance Medical Care.** Adds § 256D.031. Establishes the temporary general assistance medical care program.

Subdivision. 1. Eligibility. Establishes eligibility for the GAMC program. The criteria specified in the subdivision are from current GAMC law, except that hospital-only coverage for individuals with income greater than 75 percent of federal poverty guidelines (FPG) but not exceeding175 percent of FPG and who meet the MA asset limits for families with children no longer exists.

Subd. 2. Ineligible groups. Specifies the individuals who are ineligible for the GAMC program. Relative to current GAMC law, new exclusions include individuals who: have private health coverage; are in a correctional facility or

admitted as an inpatient to a hospital on a criminal hold order; reside in the sex offender program; or do not cooperate with a county or state agency in determining a disability for supplemental security income (SSI) or Social Security Disability Income (SSDI).

Subd. 3. Transitional MinnesotaCare. Requires certain GAMC applicants and recipients to transition to MinnesotaCare. Persons allowed to remain in GAMC are those who are:

(1) awaiting a determination of blindness or disability;

(2) homeless;

(3) Medicare end-state renal disease beneficiaries;

(4) receiving treatment paid for by through the chemical dependency fund; or

(5) fails to meet the MinnesotaCare residency requirement.

(These groups are exempt from the transition under current law. The remaining groups exempted under current law are excluded from GAMC eligibility in a previous subdivision.)

Subd. 4. Eligibility and enrollment procedures. Specifies eligibility and enrollment procedures. (No changes from current program except those related to changes in ineligible groups in subdivision 2.)

Subd. 5. General assistance medical care; services. Specifies the GAMC covered services and co-payments. (No changes from current program.)

Subd. 6. Coordinated care delivery option. (a) Allows a county or group of counties to provide health care services to individuals eligible for GAMC and who reside within the county or counties, through a coordinated care delivery option. Requires these counties to accept financial risk for the delivery of services described in subdivision 5, with the exception of outpatient prescription drug coverage (but including drugs administered in an outpatient setting).

(b) Specifies information that counties must provide to the commissioner.

(c) Allows a county to contract with a managed care plan, integrated delivery system, physician-hospital organization, or an academic health center to administer the delivery of services through this option. Allows county-based purchasing plans to continue to provide services to GAMC enrollees.

(d) Specifies county requirements.

(e) Allows the commissioner to require counties to provide data necessary for assessing quality of care, cost, and utilization.

(f) States that a county that provides services through this option shall be considered a prepaid health plan for purposes of administrative hearings.

(g) Provides that the state is not liable for any cost or obligation incurred by the county or a participating provider.

Subd. 7. Health care home designation. Allows the commissioner or a county to require GAMC recipients to designate a primary care provider or a primary care clinic that is certified as a health care home.

Subd. 8. Payments; fee-for-service rate for the period between March 1, 2010,

and July 1, 2010. Establishes a payment rate for services provided on or after March 1, 2010, and before July 1, 2010, with the exception of outpatient prescription drug coverage, at 50 percent of the GAMC rate in effect on February 28, 2010. Requires outpatient prescription drugs to be paid on a fee-for-service basis at the current statutory rate.

Subd. 9. Payments; fee-for-service rates for the period between July 1, 2010, and July 1, 2011. (a) Provides that this subdivision establishes the fee-for-service rates for services provided on or after July 1, 2010, and before July 1, 2011, to GAMC recipients who reside in counties that are not served through the coordinated care delivery option.

(b) States that the payment rate for inpatient hospital services that are provided by hospitals whose GAMC fee-for-service inpatient and outpatient hospital payments received in calendar year 2007 totaled $1 million or more, or was 1 percent or more of the hospital's net patient revenue, shall be 70 percent of the GAMC rate in effect February 28, 2010. The inpatient hospital services payment rate for hospitals that do not meet this criteria shall be 40 percent of the GAMC rate in effect on February 28, 2010.

(c) States that for all services other than inpatient hospital services and outpatient prescription drug coverage, the payment rate shall be 50 percent of the GAMC rate in effect for that service on February 28, 2010.

(d) States that reimbursement rates for outpatient prescription drug coverage provided on or after July 1, 2010, and before July 1, 2011, shall be paid on a fee-for-service basis at the current statutory rate.

(e) Allows the commissioner to adjust rates paid under paragraphs (b) and (c) on a quarterly basis to ensure that the total aggregate amount paid for services on a fee-for-service basis beginning March 1, 2010, and ending June 30, 2011, does not exceed the appropriation from the general assistance medical care account.

Subd. 10. Payments; rate setting for the coordinated care delivery system. (a) Establishes a quarterly prospective fixed payment for counties that have elected to provide services through a coordinated care delivery option, for services provided beginning July 1, 2010, and before July 1, 2011, that does not exceed 60 percent of the county's total GAMC allocation.

(b) Requires the commissioner to determine a GAMC county allocation amount that equals the total GAMC payments for recipients residing within the county for FY 2009 for all covered services, except for outpatient prescription drugs.

(c) Provides that outpatient prescription drug coverage shall be paid on a fee-for-service basis at the current statutory rates.

Subd. 11. Contact information for veterans. Requires the commissioner to ensure that county staff identify applicants who are veterans and provide contact information for the applicant's veterans service officer and information about services provided by officers.

Provides that this section is effective for services rendered on or after March 1, 2010, and before July 1, 2011.

15 **General assistance medical care account.** Adds § 256D.032. Establishes the general assistance medical care account in the special revenue fund. Specifies that money deposited

into the account is subject to appropriation by the legislature. Provides a March 1, 2010, effective date.

16 **SSI conversions and back claims.** Amends § 256D.06, subd. 7. Effective for GAMC services provided between March 1, 2010 and June 30, 2011, requires third-party medical collections, payments, or recoveries from SSI and other federal programs to be deposited in or credited to the general assistance medical care account. Provides a March 1, 2010, effective date.

17 **MinnesotaCare enrollment by county agencies.** Amends § 256L.05, subd. 1b. Makes a conforming change. Provides a March 1, 2010, effective date.

18 **Effective date of coverage.** Amends § 256L.05, subd. 3. Makes a conforming change. Provides an effective date of March 1, 2010.

19 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Makes a conforming change.

20 **Exception for certain adults.** Amends § 256L.07, subd. 6. Makes a conforming change. Provides an effective date of March 1, 2010.

21 **Health care home program for certain single adults and households without children.** Adds § 256L.121.

> **Subd. 1. Establishment; contract with commissioner.** Requires the commissioner to develop and implement, by January 1, 2012, a county-based, health care home program for persons identified by the commissioner as being more effectively served under modified MinnesotaCare. States the county participation is voluntary, and subject to approval by, and entering into a contract with, the commissioner. Lists contract requirements.
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> **Subd. 2. County requirements related to health care homes.** Requires participating counties to contract with providers certified as health care homes. Directs participating counties to requires enrollees residing in the county designate a health care home and allows counties to assign enrollees to a health care home.
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> **Subd. 3. County payment.** Requires the commissioner to pay participating counties a per capita payment that does not exceed the payment that would otherwise be made to a managed care plan. States that a county is not required to obtain an HMO certificate of authority, but must meet consumer protection, provider protection, and fiscal solvency standards established by the commissioner. States that the commissioner and state are not liable for any costs incurred by a county.
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> **Subd. 4. Nonparticipating counties.** Directs the commissioner to continue to provide MinnesotaCare services through managed care and county-based purchasing, for counties that choose not to participate in, or withdraw from the health care home program. Provides a March 1, 2010, effective date.

22 **Exception for certain adults.** Amends § 256L.15, subd. 4. The amendment to paragraph (a) requires counties to continue to pay the enrollee share of MinnesotaCare premiums for individuals transitioned from GAMC to MinnesotaCare beyond the six month period in current law. Also requires counties to pay the enrollee share of premiums for MinnesotaCare enrollees who are single adults and households with no children, with incomes not exceeding 75 percent of FPG.

A new paragraph (b) requires counties that do not participate in the health care home program to pay both the enrollee and state share of premiums for individuals who meet the criteria for modified MinnesotaCare coverage.

Provides a July 1, 2011, effective date.

23 **Exception for certain adults.** Amends § 256L.17, subd. 7. Makes a conforming change. Provides a March 1, 2010, effective date.

24 **Drug rebate program.** Requires the commissioner to continue the drug rebate program for GAMC. Requires rebates received to be deposited in the general assistance medical care account. Provides that the section is effective March 1, 2010, and expires June 30, 2011.

25 **Provider participation.** States that for purposes of the state health care program participation requirement (rule 101), GAMC includes temporary GAMC. Requires providers, in complying, to accept new patients regardless of what program the patient is enrolled in. Prohibits providers from refusing to accept patients from one program while continuing to accept patients from other programs. Provides an exemption for providers who have met the 10 and 20 percent participation thresholds. Provides a March 1, 2010, effective date.

26 **Temporary suspension.** Temporarily suspends the implementation of certain sections of the current GAMC program. Provides that the section is effective March 1, 2010, and expires July 1, 2011.

27 **Coordinated care delivery organization demonstration project.** Requires the Health Services Policy Committee to develop, and present to the legislature by December 15, 2019, a plan to establish a demonstration project to deliver inpatient hospital, primary care, and specialist services to GAMC enrollees through coordinated care delivery organizations. Specifies requirements for coordinated care delivery organizations and the plan.

Article 2: Appropriations

Overview

This article makes various appropriations, reductions, and transfers related to funding for the temporary general assistance medical care program.

Article provisions include:

- Making a one-time reduction in children and community service grants of $11.555 million in FY 2011.

- Transferring $60.406 million on March 1, 2010, from the general fund to the general assistance medical care account, and also transferring any unexpended GAMC funding to the general assistance medical care account by January 1, 2011.

- Transferring $825,000 in FY 2010 and $2.475 million in FY 2011 from the special reserve fund to the general fund, and then transferring these amounts from the general fund to the general assistance medical care

account for administration of the GAMC program.

- Transferring $1.025 million in FY 2010 and $3.075 million in FY 2011 from the special reserve fund to the general fund, and then transferring these amounts from the general fund to the general assistance medical care account for operations of the GAMC program.

- Making a one-time reduction in adult mental health grants of $7.704 million in FY 2011.
- Transferring $187.992 million in FY 2011 and $12.979 million in FY 2012 from the general fund to the general assistance medical care account.

Provides a March 1, 2010 effective date for this article.