HOUSE RESEARCH

Bill Summary

FILE NUMBER: H.F. 802 **DATE:** March 18, 2010
Version: Third engrossment

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Subject: GAMC program

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Overview

This bill modifies the General Assistance Medical Care (GAMC) program. The bill specifies eligibility criteria and covered services, allows hospitals and other providers to deliver services through a coordinated care delivery system, and establishes a prescription drug pool and a temporary uncompensated care pool.

Article 1: General Assistance Medical Care

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 **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. Provides an April 1, 2010, effective date.

3 **Quarterly payment adjustment.** Amends § 256.969, subdivision 27. Modifies language governing quarterly hospital payments. Also provides that for disproportionate share hospital funds earned on payments reported under § 256B.199, paragraphs (a) to (d) (Hennepin and Ramsey county inter-governmental transfer), for services provided on or after April 1, 2010, payment shall not be made under this subdivision. States that this section is effective for services provided on or after April 1, 2010.

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

5 **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 4.

6 **Reimbursement under other state health care programs.** Amends § 256B.0644. Provides that for purposes of the state health care program participation requirement (Rule 101), participation in GAMC applies only to pharmacy providers. Prohibits hospitals or other providers that participate in a coordinated care delivery system or receive payments from the uncompensated care pool from refusing to provide services to any patient enrolled

in GAMC, regardless of the availability or the amount of payment.

7 **Scope.** Amends § 256B.0947, subd. 1. Delays by one year, until November 1, 2011, MA coverage of medically necessary, intensive nonresidential rehabilitative mental health services.

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. Specifies the amount of monthly voluntary intergovernmental transfers to be made to the commissioner by Hennepin County and Ramsey County. Requires the commissioner to increase MA capitation payments to each health plan that agrees to make enhanced payments to HCMC or Regions Hospital by an amount equal to the value of the transfers plus federal participation. Allows the commissioner to ratably reduce payments to satisfy federal requirements for actuarial soundness. Requires plans that receive increased capitation payments to increase MA payments to HCMC and Regions Hospital by the same amount as the increase. Provides that the section is effective 60 days after federal approval.

9 **Intergovernmental transfers; inpatient hospital payments.** Adds § 256B.197.

Subd. 1. Federal approval required. Provides that the section is effective for FFY 2010 and future years, contingent on federal approval of the voluntary intergovernmental transfers and payments, and contingent on payment of the intergovernmental transfers.

Subd. 2. Eligible nonstate government hospitals. Classifies HCMC and Regions Hospital as eligible nonstate government hospitals, and allows the commissioner to include other hospitals if federal approval is obtained.

Subd. 3. Commissioner's duties. Requires the commissioner to increase the supplemental payment amount for each eligible nonstate government hospital to the Medicare upper payment limit. Requires the commissioner to inform each hospital and associated governmental entity of the intergovernmental transfer necessary to provide the nonfederal share of the supplemental payment amount, and also of any changes needed to continue the payments at their maximum level. Directs the commissioner to make supplemental payments, upon receipt of an intergovernmental transfer.

10 **Ombudsperson.** Amends § 256B.69, subd. 20. Requires the commissioner to designate an ombudsperson to advocate for persons enrolled in a coordinated care delivery system. Specifies duties and requires local agencies to inform recipients about the ombudsperson program.

11 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Provides that beginning April 1, 2010, GAMC is to be administered according to § 256D.031, unless otherwise stated, except that outpatient prescription drug coverage is to be administered under this section and funded through the prescription drug pool beginning June 1, 2010. Limits GAMC drug coverage to prescription drugs that are covered under MA and provided by manufacturers that have entered into rebate agreements. Strikes language that is either superseded by or reinstated in § 256D.031. States that outpatient prescription drug coverage does not include drugs administered in an outpatient setting. Provides an April 1, 2010, effective date.

12 **General Assistance Medical Care.** Adds § 256D.031. Establishes criteria for the 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. Eligibility and enrollment procedures. Specifies eligibility and enrollment procedures. Provides that applicants and recipients are eligible for GAMC for six-month eligibility periods, unless a change that affects eligibility is reported. States that individuals who continue to meet GAMC eligibility requirements for a six-month eligibility period are not eligible for MinnesotaCare during that eligibility period.

Subd. 4. General assistance medical care; services. (a) Provides that GAMC covers medically necessary services that include: inpatient hospital services, outpatient hospital services, services provided by Medicare-certified rehabilitation agencies, prescription drugs, certain equipment for diabetics, eyeglasses and eye examinations, hearing aids, prosthetic devices if not covered by veteran's benefits, laboratory and x-ray services, physician services, medical transportation except special transportation, chiropractic services as covered under MA, podiatric services, dental services, mental health services, certain services provided by nurse practitioners, certain public health nursing services, telemedicine, care coordination and patient education provided by a community health worker, and sign language interpreter services. Also incorporates language related to covered services from existing GAMC law and existing GAMC cost-sharing requirements.

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, provides that GAMC is paid on a fee-for-service basis and sets GAMC fee-for-service payment rates for services other than outpatient prescription drugs at 37 percent of the prior rate.

(b) Requires outpatient prescription drugs, for the period April 1, 2010, to May 31, 2010, to be paid on a fee-for-service basis as provided for under the MA program.

Subd. 6. Coordinated care delivery systems. (a) Effective June 1, 2010, requires the commissioner to contract with hospitals or groups or hospitals that qualify under paragraph (b) and agree to provide services. Requires contracting hospitals to develop and implement a coordinated care delivery system. Requires the system to provide: (1) all services described in subdivision 4, except for outpatient prescription drug coverage (but including drugs administered in an 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. These services include, at a minimum, but are not limited to, emergency care, emergency medical services, inpatient hospital and physician care, outpatient health services, preventive health services, mental health services, and

drugs administered in an outpatient setting.
(b) Effective June 1, 2010, allows hospitals that received fee-for-service GAMC payments in CY 2008 equal or greater than $1.5 million or equal or greater than 1.3 percent of net patient revenue to contract under this subdivision. Also allows the commissioner to contract with a hospital if this is necessary to provide geographic access or to ensure that at least 80 percent of enrollees have access to a coordinated care delivery system. Effective December 1, 2010, allows all other hospitals to contract under this subdivision. Provides that hospital participation becomes effective quarterly and requires renewal every 12 months.
(c) Allows applicants and recipients to enroll in any available coordinated care delivery system statewide, and allows the commissioner to assign individuals who do not make a choice to a system. Requires enrollees to agree to receive all nonemergency services through the coordinated care delivery system. Provides that recipients are not eligible to enroll in MinnesotaCare during a period of enrollment in a coordinated care delivery system. For the period June 1, 2010, to November 30, 2010, allows applicants and recipients not enrolled in a system to seek services from hospitals that are eligible to receive reimbursement from the uncompensated care pool. States that after November 30, 2010, services are available only through a coordinated care delivery system.
(d) Allows hospitals to contract and coordinate with providers and clinics for the delivery of services, and requires contracts with certain essential community providers to the extent practicable. Prohibits providers and clinics from refusing services to recipients, and states that payment rates shall be determined through negotiation.
(e) Requires a coordinated care delivery system to: (1) provide covered services to recipients enrolled in the system, and comply with subdivision 4, paragraphs (b) to (g); (2) establish a process to monitor enrollment and ensure quality of care; (3) in cooperation with counties, coordinate the delivery of health care services with support services; and (4) adopt innovative and cost-effective methods of care delivery and coordination.
(f) Allows a hospital to require a recipient to designate a primary care provider or primary care clinic. Also allows a hospital to use a provider network to deliver services, require recipients to seek services within the network, and require referrals to providers. States that a coordinated care delivery system is not required to pay providers who are not employed or under contract with the system for services provided to enrollees, except in cases of emergency.
(g) Allows recipient appeals under § 256.045.
(h) Provides that the state is not liable for any cost or obligation incurred by the coordinated care delivery system.
(i) Specifies data reporting requirements for hospitals.
(j) Effective June 1, 2010, states that limitations on hospital transfers do not apply to GAMC.

Subd. 7. Payments; rate setting for the hospital coordinated care delivery system. (a) For services (other than outpatient prescription drug coverage) provided on or after June 1, 2010, requires the commissioner to provide quarterly payments to coordinated care delivery systems, that are initially allocated based on the hospital's share of GAMC payments in CY 2008. Requires payments to HCMC, Regions, and Fairview to be weighted at 110 percent. Allows biannual reallocation of payments based on actual enrollment and updates of the base year.

(b) Requires nonhospital providers, in order to be reimbursed, to contract with a hospital to provide services to persons served through the coordinated care delivery system. Requires reimbursement to be at negotiated rates.
(c) Requires the commissioner to apply for federal matching funds for expenditures under the section.
(d) Requires outpatient prescription drugs to be paid on a fee-for-service basis.

Subd. 8. Temporary uncompensated care pool. (a) Requires the commissioner to establish a temporary uncompensated care pool, effective June 1, 2010, and requires payments to be distributed, within the limits of the appropriation, to hospitals that are not part of a coordinated care delivery system.
(b) Requires hospitals to submit invoices for services provided, and requires a payment amount to be calculated, but not paid, for each admission or service provided between June 1, 210, and November 31, 2010.
(c) Requires the aggregated payment amount for each hospital to be calculated as a percentage of the total calculated for all hospitals.
(d) Requires pool distributions to be determined by multiplying the factor calculated in paragraph (c) by the amount of money in the pool available for a six-month period.
(e) Requires the commissioner to apply for federal matching funds.
(f) States that outpatient prescription drugs are not eligible for payment under this subdivision.

Subd. 9. Prescription drug pool. (a) Requires the commissioner to establish an outpatient prescription drug pool, effective June 1, 2010. Requires money in the pool to be used to reimburse pharmacies and other pharmacy service providers for drugs dispensed to recipients on a fee-for-service basis. States that prescription drug coverage is subject to the availability of funds. If the commissioner forecasts a shortfall in funding, allows the commissioner to bring recommendations to address the shortfall to the Legislative Advisory Commission.
(b) Effective June 1, 2010, requires coordinated care delivery systems to pay the commissioner, on a quarterly basis, an assessment equal to 20 percent of payments for prescribed drugs to recipients. Requires each system's assessment to be in proportion to its share of total funding provided to coordinated care delivery systems.

Subd. 10. Assistance for veterans. Requires hospitals participating in a coordinated care delivery system to consult with counties, county veterans service officers, and the Veterans Administration to identify other programs for which GAMC recipients enrolled in their system are qualified.

Provides that this section is effective for services rendered on or after April 1, 2010.

13 **Effective date of coverage.** Amends § 256L.05, subd. 3. Makes a conforming change. Provides an effective date of January 1, 2011.

14 **Renewal of eligibility.** Amends § 256L.05, subd. 3a. Makes a conforming change. Provides an effective date of January 1, 2011.

15 **Retroactive coverage.** Amends § 256L.05, subd. 3c. Clarifies that GAMC enrollees may qualify for existing MinnesotaCare retroactive coverage at six-month renewal.

16 **Disposition of license fee.** Amends § 517.08, subd. 1c. Increases from $50 to $55 the portion of the marriage license fee that is deposited in the general fund, and eliminates the allocation of $5 of the fee to the special revenue fund for the Minnesota Healthy Marriage and Responsible Fatherhood Initiative. Provides a July 1, 2010, effective date.

17 **Drug rebate program.** Requires the commissioner to continue the drug rebate program for GAMC. Provides that the section is effective April 1, 2010.

18 **Transitional MinnesotaCare phaseout.** Provides that the transition to MinnesotaCare shall continue according to current law for individuals who meet the requirements for transition before April 1, 2010. Requires county agencies to continue to perform all duties required under the transition provisions, including the redetermination of MinnesotaCare eligibility at renewal. Provides an April 1, 2010 effective date.

19 **Revisor's instruction.** Directs the revisor to edit §§ 2565B.69 and 256B.692, to remove references to the GAMC program.

20 **Repealer.** Repeals § 256B.195 (Hennepin County and Ramsey County intergovernmental transfer and payments to safety net providers) and 256D.03, subds. 4 (GAMC covered services) and 9 (GAMC payment for ambulance services), 256.742 (MN Healthy Family and Responsible Fatherhood Initiative), and 256.979, subd. 8 (fees to MA providers for completed recognition of parentage forms). Also repeals sections of MinnesotaCare law related to transitional GAMC, effective January 1, 2011 (§ 256L.07, subd. 6; 256L.15, subd. 4; and 256L.17, subd. 7).

Article 2: Appropriations

This article makes various appropriations and reductions related to the general assistance medical care program.