HOUSE RESEARCH

Bill Summary

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Overview

This bill establishes a temporary General Assistance Medical Care (GAMC) program for the period March 1, 2010, through June 30, 2011. The bill 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 bill 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 **Hospital surcharge.** Amends § 256.9657, subd. 2. For the period March 1, 2010, to September 30, 2010, increases the hospital surcharge to 3.95 percent from 1.56 percent of net patient revenues, excluding Medicare. For the period October 1, 2010, to June 30, 2011, increases the surcharge to 3.06 percent. The additional revenue is deposited in the general assistance medical care account established later in the bill. Provides a March 1, 2010, effective date.

3 **Surcharge on HMOs and community integrated service networks.** Amends § 256.9657, subd. 3. For the period March 1, 2010, to June 30, 2011, increases the health maintenance organization surcharge from 0.6 percent of total premium revenues to 4.0 percent. Requires each county-based purchasing plan to pay a surcharge of 4.0 percent of total premium revenues for that period. The additional revenue is deposited in the general assistance medical care account. Provides a March 1, 2010, effective date.

4 **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.

5 **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.

A new paragraph (i) increases the total inpatient hospital payment rate for under medical assistance for admissions from March 1, 2010, to June 30, 2011, by 14 percent for hospitals located in Hennepin or Ramsey County, and 18 percent for all other hospitals, in order to offset rateable reductions made elsewhere in the subdivision. Requires the increase to be paid from the general assistance medical care account. Prohibits the commissioner from adjusting prepaid health plan rates to reflect the increase and states that plans are not required to increase provider rates. Allows the commissioner to use a settlement process to adjust rates in excess of the Medicare upper payment limit. Allows the commissioner to reduce payment rates under this paragraph to comply with the rate floor established for certain safety net hospitals under § 256B.195, subdivision 3, paragraph (f). Provides a March 1, 2010, effective date.

6 **Mental health or chemical dependency admissions; rates.** Amends § 256.969, subd. 21. In order to ensure adequate access to mental health services and encourage broader delivery outside the nonstate governmental hospital setting, increases payments for MA admissions occurring between March 1, 2010, to June 30, 2011, at a private, not-for-profit hospital with MA mental health admissions for specified diagnosis-related groups above the 75th

percentile, for those diagnosis-related groups by a percentage calculated not to cost more than $40,000,000, including state and federal shares. Requires the increase to be paid from the general assistance medical care account. Prohibits the commissioner from adjusting prepaid health plan rates to reflect this increase and states that plans are not required to increase provider rates. Allows the commissioner to use a settlement process to adjust rates in excess of the Medicare upper payment limit. Allows the commissioner to reduce payment rates under this paragraph to comply with the rate floor established for certain safety net hospitals under § 256B.195, subdivision 3, paragraph (f). Provides a March 1, 2010, effective date.

7 **Greater Minnesota payment adjustment after June 30, 2001.** Amends § 256.969, subd. 26. For the period March 1, 2010, to June 30, 2011, increases the payment rate to hospitals located outside of the seven-county metropolitan area for specified diagnosis-related groups from 90 to 100 percent of the average payment rate for hospitals located within the seven-county metropolitan area. Requires the increase to be paid from the general assistance medical care account. States that for purposes of the paragraph, Medical Assistance (MA) does not include GAMC. Prohibits the commissioner from adjusting prepaid health plan rates to reflect this increase and states that plans are not required to increase provider rates. Allows the commissioner to use a settlement process to adjust rates in excess of the Medicare upper payment limit. Allows the commissioner to reduce payment rates under this paragraph to comply with the rate floor established for certain safety net hospitals under § 256B.195, subdivision 3, paragraph (f). Provides a March 1, 2010, effective date.

8 **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 state share. Specifies that this provision does not apply to GAMC.
(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 and hospital-specific charge limits.

9 **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. States that this section is effective for services provided on or after March 1, 2010.

10 **Payment rates for births.** Amends § 256.969, subd. 30. In order to ensure adequate access to maternity services and encourage broader delivery of these services outside the nonstate governmental hospital setting, increases payments for MA admissions for specified diagnosis-related groups occurring between March 1, 2010, to June 30, 2011, at a private,

not-for-profit hospital with MA admissions above the 65th percentile for deliveries paid by MA for those specified diagnosis-related groups by a percentage calculated not to cost more than $35,000,000, including state and federal shares. Requires the increase to be paid from the general assistance medical care account. States that for purposes of the paragraph, MA does not include GAMC. Prohibits the commissioner from adjusting prepaid health plan rates to reflect this increase and states that plans are not required to increase provider rates. Allows the commissioner to use a settlement process to adjust rates in excess of the Medicare upper payment limit. Allows the commissioner to reduce payment rates under this paragraph to comply with the rate floor established for certain safety net hospitals under § 256B.195, subdivision 3, paragraph (f). Provides a March 1, 2010, effective date.

11 **Rate increase for hospitals in cities of the third and fourth class.** Amends § 256.969, by adding subd. 31. Effective for services provided between March 1, 2010, to June 30, 2011, increases MA payments for MA admissions by 27 percent, for hospitals with fewer than 500 MA admissions during FY 2008 and located in cities of the third or fourth class. Requires the increase to be paid from the general assistance medical care account.

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

13 **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.

14 **Payments to certain safety net providers.** Amends § 256B.195, subd. 3. Sets a floor for payments to various safety net hospitals from intergovernmental transfers, by requiring payments for FFY 2010 and 2011 to be made at no less than the FFY 2009 level. Provides a March 1, 2010, effective date.

15 **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 agrees to provide enhanced payments to Hennepin County Medical Center or Regions Hospital for providing services to MinnesotaCare enrollees, by an amount equal to the plan's increase in capitation payments as a result of the intergovernmental transfers.

16 **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.

17 **Temporary rate modifications.** Amends § 256B.69, by adding subdivision 5k. For the period May 1, 2010, to June 30, 2011, increases MA managed care plan payments and MinnesotaCare payments for families and children by 4.61 percent. Requires this increase to be paid from the general assistance medical care account. Provides a March 1, 2010, effective date.

18 **General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. 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.

19 **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.

20 **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.

21 **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 and supportive 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 69 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 60 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.

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

22 **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 and shall be used only for expenditures related to the GAMC program or as provided in this act. Provides a March 1, 2010, effective date.

23 **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.

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

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

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

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

28 **Exception for transitioned adults.** Amends § 256L.15, subd. 4. Makes a conforming

change. Provides an effective date of March 1, 2010.

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

30 **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.

31 **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 a March 1, 2010, effective date.

32 **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.

33 **Coordinated care delivery organization demonstration project.** Requires the commissioner of human services to develop, and present to the legislature by December 15, 2019, a plan to establish a demonstration project to delivery 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.

34 **Minnesota Comprehensive Health Association assessment modification; transfer.**

Subd. 1. Minnesota Comprehensive Health Association assessment modification. For purposes of the annual MCHA assessment, credits $21,875,000 towards the HealthPartners' assessment for calendar year 2010 and $13,125,000 toward the 2011 assessment.

Subd. 2. Transfer. Transfers specified amounts in FY 2010 and FY 2011 from the general assistance medical care account to the commissioner of commerce, to compensate for the loss in MCHA assessments created by the credit established in subdivision 1.

35 **Appropriation transfers.** Transfers on March 1, 2010, certain appropriations for health care administration and health care operations to the general assistance medical care account. Transfers money from the FY 2010 general fund appropriation for GAMC to the general assistance medical care account and provides that unexpended amounts shall also be transferred. Provides a March 1, 2010, effective date.

36 **Appropriations; hospital grants.** Appropriates $8 million from the general fund to the commissioner for grants to hospitals. Requires the commissioner, after consulting with the Minnesota Hospital Association, to develop criteria for awarding grants. Requires the criteria to reflect the difference in 2009 GAMC revenue, or actual 2010 revenue, whichever is greater, plus additional MA revenue.

37 **Appropriation reduction; transfer.** For FY 2011, reduces the general fund appropriation for children and community services grants by $9,560,500, and reduces the general fund appropriation for the adult mental health integrated fund by the same amount. Transfers $19,121,000 in FY 2011 from the general fund to the general assistance medical care account.

38 **Appropriations.** Appropriates money from the general assistance medical care account to the commissioner of human services for the hospital and managed care plan rate increases, and for the general assistance medical care program. Provides a March 1, 2010, effective date.