SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 1284

(SENATE AUTHORS: HANN)

DATE	D-PG	OFFICIAL STATUS
04/26/2011	1406	Introduction and first reading Referred to Health and Human Services
05/02/2011	1552a	Comm report: To pass as amended
	1604	Second reading
05/20/2011	3024	Special Order
	3025	Third reading Passed

A bill for an act

relating to human services; making changes to health care program provisions; making technical and policy changes; clarifying obsolete language; making federal conformity changes; clarifying eligibility requirements; modifying pharmaceutical provisions; clarifying certain covered services; eliminating the elderly waiver payment; providing a right to appeal and appeal processes; imposing provider requirements; requiring a report on nonemergency medical transportation; requiring reporting of managed care and county-based purchasing data; providing civil penalties; amending Minnesota Statutes 2010, sections 13.461, subdivision 24a; 256B.02, by adding a subdivision; 256B.03, by adding subdivisions; 256B.04, by adding a subdivision; 256B.056, subdivisions 1c, 3, 3c; 256B.057, subdivision 9; 256B.0625, subdivisions 13, 13d, 13e, 17a, 22, 30, 31, by adding subdivisions; 256B.064, subdivisions 1a, 1b, 2; 256B.0641, subdivision 1; 256B.0659, subdivision 30; 256B.199; 256B.27, subdivision 3; 256B.69, subdivisions 5, 28, by adding a subdivision; 256B.76, subdivision 4; 256L.04, subdivision 7b; 256L.05, subdivision 3; 256L.11, subdivision 6; 256L.15, subdivision 1; Laws 2010, First Special Session chapter 1, article 16, sections 8; 9; 10; repealing Minnesota Statutes 2010, sections 256.01, subdivision 18b; 256B.69, subdivision 9b.

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

ARTICLE 1

REHABILITATION TECHNICAL

Section 1. Laws 2010, First Special Session chapter 1, article 16, section 8, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service~~, and January 1, 2011, for services provided through managed care~~.

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

Sec. 2. Laws 2010, First Special Session chapter 1, article 16, section 9, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service~~, and January 1, 2011, for services provided through managed care~~.

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

Sec. 3. Laws 2010, First Special Session chapter 1, article 16, section 10, the effective date, is amended to read:

EFFECTIVE DATE. This section is effective July 1, 2010, for services provided through fee-for-service~~, and January 1, 2011, for services provided through managed care~~.

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

ARTICLE 2

PERSONAL CARE ASSISTANCE SERVICES

Section 1. Minnesota Statutes 2010, section 256B.0659, subdivision 30, is amended to read:

Subd. 30. **Notice of service changes to recipients.** The commissioner must provide:

(1) by October 31, 2009, information to recipients likely to be affected that (i) describes the changes to the personal care assistance program that may result in the loss of access to personal care assistance services, and (ii) includes resources to obtain further information;

(2) notice of changes in medical assistance personal care assistance services to each affected recipient at least 30 days before the effective date of the change.

The notice shall include how to get further information on the changes, how to get help to obtain other services, a list of community resources, and appeal rights. Notwithstanding section 256.045, a recipient may request continued services pending appeal within ~~the time period allowed to request an appeal~~ 30 days after the notice of change in personal care assistance services, or before the effective date of action, whichever is later. A managed care enrollee may request continuation of services pending an appeal to the state within ten days after the written resolution of a managed care organization appeal, or before the effective date of action, whichever is later; and

(3) a service agreement authorizing personal care assistance hours of service at the previously authorized level, throughout the appeal process period, when a recipient requests services pending an appeal.

ARTICLE 3

FEDERAL POVERTY GUIDELINES

Section 1. Minnesota Statutes 2010, section 256B.056, subdivision 1c, is amended to read:

Subd. 1c. **Families with children income methodology.** (a)(1) [Expired, 1Sp2003 c 14 art 12 s 17]

(2) For applications processed within one calendar month prior to July 1, 2003, eligibility shall be determined by applying the income standards and methodologies in effect prior to July 1, 2003, for any months in the six-month budget period before July 1, 2003, and the income standards and methodologies in effect on July 1, 2003, for any months in the six-month budget period on or after that date. The income standards for each month shall be added together and compared to the applicant's total countable income for the six-month budget period to determine eligibility.

(3) For children ages one through 18 whose eligibility is determined under section 256B.057, subdivision 2, the following deductions shall be applied to income counted toward the child's eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: $90 work expense, dependent care, and child support paid under court order. This clause is effective October 1, 2003.

(b) For families with children whose eligibility is determined using the standard specified in section 256B.056, subdivision 4, paragraph (c), 17 percent of countable earned income shall be disregarded for up to four months and the following deductions shall be applied to each individual's income counted toward eligibility as allowed under the state's AFDC plan in effect as of July 16, 1996: dependent care and child support paid under court order.

(c) If the four-month disregard in paragraph (b) has been applied to the wage earner's income for four months, the disregard shall not be applied again until the wage earner's income has not been considered in determining medical assistance eligibility for 12 consecutive months.

(d) 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 except that the income standards shall not go below ~~those~~ the income standards in effect on July 1~~, 2009~~ of the preceding year.

(e) For children age 18 or under, annual gifts of $2,000 or less by a tax-exempt organization to or for the benefit of the child with a life-threatening illness must be disregarded from income.

Sec. 2. Minnesota Statutes 2010, section 256L.04, subdivision 7b, is amended to read:

Subd. 7b. **Annual income limits adjustment.** The commissioner shall adjust the income limits 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 except that the income standards shall not go below ~~those~~ the income standards in effect on the preceding July 1~~, 2009~~.

ARTICLE 4

CLARIFICATION OF AMERICAN INDIAN LANGUAGE IN ARRA

Section 1. Minnesota Statutes 2010, section 256B.056, subdivision 3, is amended to read:

Subd. 3. **Asset limitations for individuals and families.** (a) To be eligible for medical assistance, a person must not individually own more than $3,000 in assets, or if a member of a household with two family members, husband and wife, or parent and child, the household must not own more than $6,000 in assets, plus $200 for each additional legal dependent. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The accumulation of the clothing and personal needs allowance according to section 256B.35 must also be reduced to the maximum at the time of the eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance is the value of those assets excluded under the supplemental security income program for aged, blind, and disabled persons, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business that the local agency determines are necessary to the person's ability to earn an income are not considered;

(3) motor vehicles are excluded to the same extent excluded by the supplemental security income program;

(4) assets designated as burial expenses are excluded to the same extent excluded by the supplemental security income program. Burial expenses funded by annuity contracts or life insurance policies must irrevocably designate the individual's estate as contingent beneficiary to the extent proceeds are not used for payment of selected burial expenses; ~~and~~

(5) effective upon federal approval, for a person who no longer qualifies as an employed person with a disability due to loss of earnings, assets allowed while eligible for medical assistance under section 256B.057, subdivision 9, are not considered for 12 months, beginning with the first month of ineligibility as an employed person with a disability, to the extent that the person's total assets remain within the allowed limits of section 256B.057, subdivision 9, paragraph (c)~~.~~; and

(6) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this clause, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(b) No asset limit shall apply to persons eligible under section 256B.055, subdivision 15.

Sec. 2. Minnesota Statutes 2010, section 256B.056, subdivision 3c, is amended to read:

Subd. 3c. **Asset limitations for families and children.** A household of two or more persons must not own more than $20,000 in total net assets, and a household of one person must not own more than $10,000 in total net assets. In addition to these maximum amounts, an eligible individual or family may accrue interest on these amounts, but they must be reduced to the maximum at the time of an eligibility redetermination. The value of assets that are not considered in determining eligibility for medical assistance for families and children is the value of those assets excluded under the AFDC state plan as of July 16, 1996, as required by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (PRWORA), Public Law 104-193, with the following exceptions:

(1) household goods and personal effects are not considered;

(2) capital and operating assets of a trade or business up to $200,000 are not considered, except that a bank account that contains personal income or assets, or is used to pay personal expenses, is not considered a capital or operating asset of a trade or business;

(3) one motor vehicle is excluded for each person of legal driving age who is employed or seeking employment;

(4) assets designated as burial expenses are excluded to the same extent they are excluded by the Supplemental Security Income program;

(5) court-ordered settlements up to $10,000 are not considered;

(6) individual retirement accounts and funds are not considered; ~~and~~

(7) assets owned by children are not considered~~.~~; and

(8) effective July 1, 2009, certain assets owned by American Indians are excluded, as required by section 5006 of the American Recovery and Reinvestment Act of 2009,

Public Law 111-5. For purposes of this clause, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

The assets specified in clause (2) must be disclosed to the local agency at the time of application and at the time of an eligibility redetermination, and must be verified upon request of the local agency.

Sec. 3. Minnesota Statutes 2010, section 256B.057, subdivision 9, is amended to read:

Subd. 9. **Employed persons with disabilities.** (a) Medical assistance may be paid for a person who is employed and who:

(1) but for excess earnings or assets, meets the definition of disabled under the Supplemental Security Income program;

(2) is at least 16 but less than 65 years of age;

(3) meets the asset limits in paragraph (c); and

(4) pays a premium and other obligations under paragraph (e).

Any spousal income or assets shall be disregarded for purposes of eligibility and premium determinations.

(b) After the month of enrollment, a person enrolled in medical assistance under this subdivision who:

(1) is temporarily unable to work and without receipt of earned income due to a medical condition, as verified by a physician, may retain eligibility for up to four calendar months; or

(2) effective January 1, 2004, loses employment for reasons not attributable to the enrollee, may retain eligibility for up to four consecutive months after the month of job loss. To receive a four-month extension, enrollees must verify the medical condition or provide notification of job loss. All other eligibility requirements must be met and the enrollee must pay all calculated premium costs for continued eligibility.

(c) For purposes of determining eligibility under this subdivision, a person's assets must not exceed $20,000, excluding:

(1) all assets excluded under section 256B.056;

(2) retirement accounts, including individual accounts, 401(k) plans, 403(b) plans, Keogh plans, and pension plans; and

(3) medical expense accounts set up through the person's employer.

(d)(1) Effective January 1, 2004, for purposes of eligibility, there will be a $65 earned income disregard. To be eligible, a person applying for medical assistance under this subdivision must have earned income above the disregard level.

(2) Effective January 1, 2004, to be considered earned income, Medicare, Social Security, and applicable state and federal income taxes must be withheld. To be eligible, a person must document earned income tax withholding.

(e)(1) (i) Except as provided in item (ii), a person whose earned and unearned income is equal to or greater than 100 percent of federal poverty guidelines for the applicable family size must pay a premium to be eligible for medical assistance under this subdivision. The premium shall be based on the person's gross earned and unearned income and the applicable family size using a sliding fee scale established by the commissioner, which begins at one percent of income at 100 percent of the federal poverty guidelines and increases to 7.5 percent of income for those with incomes at or above 300 percent of the federal poverty guidelines. Annual adjustments in the premium schedule based upon changes in the federal poverty guidelines shall be effective for premiums due in July of each year.

(ii) Effective July 1, 2009, American Indians are exempt from paying premiums as required by section 5006 of the American Recovery and Reinvestment Act of 2009, Public Law 111-5. For purposes of this paragraph, an American Indian is a person who meets the definition of Indian according to Code of Federal Regulations, title 42, section 447.50.

(2) Effective January 1, 2004, all enrollees must pay a premium to be eligible for medical assistance under this subdivision. An enrollee shall pay the greater of a $35 premium or the premium calculated in clause (1).

(3) Effective November 1, 2003, all enrollees who receive unearned income must pay one-half of one percent of unearned income in addition to the premium amount.

(4) Effective November 1, 2003, for enrollees whose income does not exceed 200 percent of the federal poverty guidelines and who are also enrolled in Medicare, the commissioner must reimburse the enrollee for Medicare Part B premiums under section 256B.0625, subdivision 15, paragraph (a).

(5) Increases in benefits under title II of the Social Security Act shall not be counted as income for purposes of this subdivision until July 1 of each year.

(f) A person's eligibility and premium shall be determined by the local county agency. Premiums must be paid to the commissioner. All premiums are dedicated to the commissioner.

(g) Any required premium shall be determined at application and redetermined at the enrollee's six-month income review or when a change in income or household size is reported. Enrollees must report any change in income or household size within ten days of when the change occurs. A decreased premium resulting from a reported change in income or household size shall be effective the first day of the next available billing month

after the change is reported. Except for changes occurring from annual cost-of-living increases, a change resulting in an increased premium shall not affect the premium amount until the next six-month review.

(h) Premium payment is due upon notification from the commissioner of the premium amount required. Premiums may be paid in installments at the discretion of the commissioner.

(i) Nonpayment of the premium shall result in denial or termination of medical assistance unless the person demonstrates good cause for nonpayment. Good cause exists if the requirements specified in Minnesota Rules, part 9506.0040, subpart 7, items B to D, are met. Except when an installment agreement is accepted by the commissioner, all persons disenrolled for nonpayment of a premium must pay any past due premiums as well as current premiums due prior to being reenrolled. Nonpayment shall include payment with a returned, refused, or dishonored instrument. The commissioner may require a guaranteed form of payment as the only means to replace a returned, refused, or dishonored instrument.

(j) The commissioner shall notify enrollees annually beginning at least 24 months before the person's 65th birthday of the medical assistance eligibility rules affecting income, assets, and treatment of a spouse's income and assets that will be applied upon reaching age 65.

Sec. 4. Minnesota Statutes 2010, 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 either the first premium payment or documentation of American Indian status according to section 256L.15, subdivision 1, paragraph (d), 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.

Sec. 5. Minnesota Statutes 2010, section 256L.15, subdivision 1, is amended to read:

Subdivision 1. **Premium determination.** (a) Families with children and individuals shall pay a premium determined according to subdivision 2.

(b) Pregnant women and children under age two are exempt from the provisions of section 256L.06, subdivision 3, paragraph (b), clause (3), requiring disenrollment for failure to pay premiums. For pregnant women, this exemption continues until the first day of the month following the 60th day postpartum. Women who remain enrolled during pregnancy or the postpartum period, despite nonpayment of premiums, shall be disenrolled on the first of the month following the 60th day postpartum for the penalty period that otherwise applies under section 256L.06, unless they begin paying premiums.

(c) Members of the military and their families who meet the eligibility criteria for MinnesotaCare upon eligibility approval made within 24 months following the end of the member's tour of active duty shall have their premiums paid by the commissioner. The effective date of coverage for an individual or family who meets the criteria of this paragraph shall be the first day of the month following the month in which eligibility is approved. This exemption applies for 12 months. This paragraph expires June 30, 2010. If the expiration of this provision is in violation of section 5001 of Public Law 111-5, this provision will expire on the date when it is no longer subject to section 5001 of Public Law 111-5. The commissioner of human services shall notify the revisor of statutes of that date.

(d) Beginning July 1, 2009, American Indians enrolled in MinnesotaCare and their families must have their premiums waived by the commissioner in accordance with section 5006 of Public Law 111-5. An individual must document status as an American Indian, as defined under Code of Federal Regulations, title 42, section 447.50, to qualify for the exception from premium requirements.

Sec. 6. **REPEALER.**

Minnesota Statutes 2010, section 256.01, subdivision 18b, is repealed.

ARTICLE 5

ACTIVE PHARMACEUTICAL INGREDIENTS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) For the purpose of this subdivision, an "active pharmaceutical ingredient" is defined as a substance that is represented for use in a drug and that, when used in the manufacturing, processing, or packaging of a drug, becomes an active ingredient of the drug product. An excipient is defined as an inert substance used as a diluent or vehicle for a drug. The commissioner shall establish a list of active pharmaceutical ingredients and excipients which are included in the medical assistance formulary. Medical assistance covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions when the compounded combination is specifically approved by the commissioner or when:

(1) a commercially available product is not a therapeutic option for the patient;

(2) a commercially available product does not exist in the same combination of active ingredients in the same strengths as the compounded prescription; and

(3) a commercially available product cannot be used in place of the active pharmaceutical ingredient in the compounded prescription.

~~(c)~~ (d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the

requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals.

~~(d)~~ (e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

Sec. 2. Minnesota Statutes 2010, section 256B.0625, subdivision 13d, is amended to read:

Subd. 13d. **Drug formulary.** (a) The commissioner shall establish a drug formulary. Its establishment and publication shall not be subject to the requirements of the Administrative Procedure Act, but the Formulary Committee shall review and comment on the formulary contents.

(b) The formulary shall not include:

(1) drugs, active pharmaceutical ingredients, or products for which there is no federal funding;

(2) over-the-counter drugs, except as provided in subdivision 13;

(3) drugs or active pharmaceutical ingredients used for weight loss, except that medically necessary lipase inhibitors may be covered for a recipient with type II diabetes;

(4) drugs or active pharmaceutical ingredients when used for the treatment of impotence or erectile dysfunction;

(5) drugs or active pharmaceutical ingredients for which medical value has not been established; and

(6) drugs from manufacturers who have not signed a rebate agreement with the Department of Health and Human Services pursuant to section 1927 of title XIX of the Social Security Act.

(c) If a single-source drug used by at least two percent of the fee-for-service medical assistance recipients is removed from the formulary due to the failure of the manufacturer to sign a rebate agreement with the Department of Health and Human Services, the commissioner shall notify prescribing practitioners within 30 days of receiving notification from the Centers for Medicare and Medicaid Services (CMS) that a rebate agreement was not signed.

ARTICLE 6

MINIMUM QUANTITY OF OVER-THE-COUNTER DRUGS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 13, is amended to read:

Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs when specifically used to enhance fertility, if prescribed by a licensed practitioner and dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance program as a dispensing physician, or by a physician, physician assistant, or a nurse practitioner employed by or under contract with a community health board as defined in section 145A.02, subdivision 5, for the purposes of communicable disease control.

(b) The dispensed quantity of a prescription drug must not exceed a 34-day supply, unless authorized by the commissioner.

(c) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the lower of:

(1) the number of dosage units contained in the manufacturer's original package; and

(2) the number of dosage units required to complete the patient's course of therapy.

(d) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

Sec. 2. Minnesota Statutes 2010, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. Effective July 1, 2009, the actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 15 percent. The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under

this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. ~~Over-the-counter medications must be dispensed in the manufacturer's unopened package.~~ The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be on the basis of the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider or the amount established for Medicare by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act.

(e) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in

the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

(f) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

ARTICLE 7

AMBULANCE REIMBURSEMENT

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 17a, is amended to read:

Subd. 17a. **Payment for ambulance services.** Medical assistance covers ambulance services. Providers shall bill ambulance services ~~according to Medicare criteria.~~ using diagnosis codes indicating the condition that was treated by the ambulance crew. The list of advanced life support and basic life support covered diagnosis codes must be updated monthly and available on the department's Web site. Nonemergency ambulance services shall not be paid as emergencies. Effective for services rendered on or after July 1, 2001, medical assistance payments for ambulance services shall be paid at the Medicare reimbursement rate or at the medical assistance payment rate in effect on July 1, 2000, whichever is greater.

ARTICLE 8

HOSPICE AGE

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 22, is amended to read:

Subd. 22. **Hospice care.** Medical assistance covers hospice care services under ~~Public Law 99-272, section 9505~~ United States Code, title 42, section 1396d(o), to the extent authorized by rule, except that a recipient age ~~21~~ 20 or under who elects to receive hospice services does not waive coverage for services that are related to the treatment of the condition for which a diagnosis of terminal illness has been made.

ARTICLE 9

INVESTIGATIVE HEALTH SERVICES

Section 1. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 55. **Investigative health services.** (a) Medical assistance does not cover health services or items that are investigative. A health service or item that is not a drug is considered investigative if it meets any of the following criteria:

(1) the effectiveness of the health service or item in treatment of the recipient's medical condition is not supported by the available evidence;

(2) the health service or item has not progressed to or been determined effective through limited human application and trial;

(3) the health service or item lacks wide recognition as a proven and effective treatment for the recipient's medical condition;

(4) the effectiveness of the health service or item has not been established for the patient population to which the recipient belongs;

(5) the health service or item has been determined to be investigative for treatment of the recipient's medical condition under the applicable policy established by the current contracted medical reviewer;

(6) the health service or item has been determined to be investigative for treatment of the recipient's medical condition by the commissioner following review of the service by the Health Services Advisory Council; or

(7) a device involved in the health service or item is being used in a manner for which is has not been declared safe and effective by the United States Food and Drug Administration.

(b) The commissioner may, when medically necessary and appropriate, cover medical devices that have been granted a humanitarian use device exception by the United States Food and Drug Administration. Those services and items covered under this provision must be provided for the specific conditions and patient populations for which they have received such designation.

(c) Medical assistance does not cover drugs that are investigative. A drug is considered investigative if it meets either of the following:

(1) the drug is considered investigational by the United States Food and Drug Administration; or

(2) the drug does not have United States Food and Drug Administration marketing approval for any use.

ARTICLE 10

DURABLE MEDICAL EQUIPMENT DEFINITION AND ACCREDITATION FOR SUPPLIERS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/MR recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient. The commissioner may set reimbursement rates for specified categories of medical supplies at levels below the Medicare payment rate.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is provided to correct or accommodate a physiological disorder or physical condition;

(3) is suitable for use in the recipient's residence;

(4) is used primarily for a medical purpose; and

(5) is generally not useful in the absence of an illness or injury.

ARTICLE 11

ELIMINATE ELDERLY WAIVER PAYMENT

Section 1. Minnesota Statutes 2010, section 256B.69, subdivision 5, is amended to read:

Subd. 5. **Prospective per capita payment.** The commissioner shall establish the method and amount of payments for services. The commissioner shall annually contract with demonstration providers to provide services consistent with these established methods and amounts for payment.

If allowed by the commissioner, a demonstration provider may contract with an insurer, health care provider, nonprofit health service plan corporation, or the commissioner, to provide insurance or similar protection against the cost of care provided by the demonstration provider or to provide coverage against the risks incurred by demonstration providers under this section. The recipients enrolled with a demonstration provider are a permissible group under group insurance laws and chapter 62C, the Nonprofit Health Service Plan Corporations Act. Under this type of contract, the insurer or corporation may make benefit payments to a demonstration provider for services rendered or to be rendered to a recipient. Any insurer or nonprofit health service plan corporation licensed to do business in this state is authorized to provide this insurance or similar protection.

Payments to providers participating in the project are exempt from the requirements of sections 256.966 and 256B.03, subdivision 2. The commissioner shall complete development of capitation rates for payments before delivery of services under this section is begun. For payments made during calendar year 1990 and later years, the commissioner shall contract with an independent actuary to establish prepayment rates.

By January 15, 1996, the commissioner shall report to the legislature on the methodology used to allocate to participating counties available administrative reimbursement for advocacy and enrollment costs. The report shall reflect the commissioner's judgment as to the adequacy of the funds made available and of the methodology for equitable distribution of the funds. The commissioner must involve participating counties in the development of the report.

Beginning July 1, 2004, the commissioner may include payments for elderly waiver services and 180 days of nursing home care in capitation payments for the prepaid medical assistance program for recipients age 65 and older. ~~Payments for elderly waiver services shall be made no earlier than the month following the month in which services were received.~~

ARTICLE 12

SPECIAL NEEDS BASIC CARE MEDICAID SERVICES

Section 1. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with demonstration providers and sponsors of qualified Medicare-approved special needs plans, to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.

(b) Beginning January 1, 2007, the commissioner may contract with demonstration providers and sponsors of qualified Medicare special needs plans, to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for

Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Beginning January 1, 2008, the commissioner may expand contracting under this subdivision to all persons with disabilities not otherwise required to enroll in managed care.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may mail marketing materials to potential enrollees on behalf of health plans, in which case the health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

ARTICLE 13

HEALTH SERVICES ADVISORY COUNCIL

Section 1. **REVISOR'S INSTRUCTION.**

The revisor shall change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever it appears in statutes.

ARTICLE 14

COMMUNITY CLINICS

Section 1. Minnesota Statutes 2010, section 256B.0625, subdivision 30, is amended to read:

Subd. 30. **Other clinic services.** (a) Medical assistance covers rural health clinic services, federally qualified health center services, nonprofit community health clinic

services, and public health clinic services. Rural health clinic services and federally qualified health center services mean services defined in United States Code, title 42, section 1396d(a)(2)(B) and (C). Payment for rural health clinic and federally qualified health center services shall be made according to applicable federal law and regulation.

(b) A federally qualified health center that is beginning initial operation shall submit an estimate of budgeted costs and visits for the initial reporting period in the form and detail required by the commissioner. A federally qualified health center that is already in operation shall submit an initial report using actual costs and visits for the initial reporting period. Within 90 days of the end of its reporting period, a federally qualified health center shall submit, in the form and detail required by the commissioner, a report of its operations, including allowable costs actually incurred for the period and the actual number of visits for services furnished during the period, and other information required by the commissioner. Federally qualified health centers that file Medicare cost reports shall provide the commissioner with a copy of the most recent Medicare cost report filed with the Medicare program intermediary for the reporting year which support the costs claimed on their cost report to the state.

(c) In order to continue cost-based payment under the medical assistance program according to paragraphs (a) and (b), a federally qualified health center or rural health clinic must apply for designation as an essential community provider within six months of final adoption of rules by the Department of Health according to section 62Q.19, subdivision 7. For those federally qualified health centers and rural health clinics that have applied for essential community provider status within the six-month time prescribed, medical assistance payments will continue to be made according to paragraphs (a) and (b) for the first three years after application. For federally qualified health centers and rural health clinics that either do not apply within the time specified above or who have had essential community provider status for three years, medical assistance payments for health services provided by these entities shall be according to the same rates and conditions applicable to the same service provided by health care providers that are not federally qualified health centers or rural health clinics.

(d) Effective July 1, 1999, the provisions of paragraph (c) requiring a federally qualified health center or a rural health clinic to make application for an essential community provider designation in order to have cost-based payments made according to paragraphs (a) and (b) no longer apply.

(e) Effective January 1, 2000, payments made according to paragraphs (a) and (b) shall be limited to the cost phase-out schedule of the Balanced Budget Act of 1997.

(f) Effective January 1, 2001, each federally qualified health center and rural health clinic may elect to be paid either under the prospective payment system established in United States Code, title 42, section 1396a(aa), or under an alternative payment methodology consistent with the requirements of United States Code, title 42, section 1396a(aa), and approved by the Centers for Medicare and Medicaid Services. The alternative payment methodology shall be 100 percent of cost as determined according to Medicare cost principles.

(g) For purposes of this section, "nonprofit community clinic" is a clinic that:

(1) has nonprofit status as specified in chapter 317A;

(2) has tax exempt status as provided in Internal Revenue Code, section 501(c)(3);

(3) is established to provide health services to low-income population groups, uninsured, high-risk and special needs populations, underserved and other special needs populations;

(4) employs professional staff at least one-half of which are familiar with the cultural background of their clients;

(5) charges for services on a sliding fee scale designed to provide assistance to low-income clients based on current poverty income guidelines and family size; ~~and~~

(6) does not restrict access or services because of a client's financial limitations or public assistance status and provides no-cost care as needed~~.~~; and

(7) does not limit state health care program patients under section 256B.0644, paragraphs (b) and (c).

Sec. 2. Minnesota Statutes 2010, section 256B.76, subdivision 4, is amended to read:

Subd. 4. **Critical access dental providers.** (a) Effective for dental services rendered on or after January 1, 2002, the commissioner shall increase reimbursements to dentists and dental clinics deemed by the commissioner to be critical access dental providers. For dental services rendered on or after July 1, 2007, the commissioner shall increase reimbursement by 30 percent above the reimbursement rate that would otherwise be paid to the critical access dental provider. The commissioner shall pay the managed care plans and county-based purchasing plans in amounts sufficient to reflect increased reimbursements to critical access dental providers as approved by the commissioner.

(b) The commissioner shall designate the following dentists and dental clinics as critical access dental providers:

(1) nonprofit community clinics that:

(i) have nonprofit status in accordance with chapter 317A;

(ii) have tax exempt status in accordance with the Internal Revenue Code, section 501(c)(3);

(iii) are established to provide oral health services to patients who are low income, uninsured, have special needs, and are underserved;

(iv) have professional staff familiar with the cultural background of the clinic's patients;

(v) charge for services on a sliding fee scale designed to provide assistance to low-income patients based on current poverty income guidelines and family size;

(vi) do not restrict access or services because of a patient's financial limitations or public assistance status; ~~and~~

(vii) have free care available as needed; and

(viii) does not limit state health care program patients under section 256B.0644, paragraphs (b) and (c);

(2) federally qualified health centers, rural health clinics, and public health clinics;

(3) county owned and operated hospital-based dental clinics;

(4) a dental clinic or dental group owned and operated by a nonprofit corporation in accordance with chapter 317A with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance, general assistance medical care, or MinnesotaCare; and

(5) a dental clinic associated with an oral health or dental education program operated by the University of Minnesota or an institution within the Minnesota State Colleges and Universities system.

(c) The commissioner may designate a dentist or dental clinic as a critical access dental provider if the dentist or dental clinic is willing to provide care to patients covered by medical assistance, general assistance medical care, or MinnesotaCare at a level which significantly increases access to dental care in the service area.

(d) Notwithstanding paragraph (a), critical access payments must not be made for dental services provided from April 1, 2010, through June 30, 2010.

ARTICLE 15

DISPROPORTIONATE SHARE HOSPITAL PAYMENTS UNDER MINNESOTACARE

Section 1. Minnesota Statutes 2010, section 256B.199, is amended to read:

256B.199 PAYMENTS REPORTED BY GOVERNMENTAL ENTITIES.

(a) Effective July 1, 2007, the commissioner shall apply for federal matching funds for the expenditures in paragraphs (b) and (c). Effective July 1, 2011, the commissioner shall apply for matching funds for expenditures in paragraph (e).

(b) The commissioner shall apply for federal matching funds for certified public expenditures as follows:

(1) Hennepin County, Hennepin County Medical Center, Ramsey County, Regions Hospital, the University of Minnesota, and Fairview-University Medical Center shall report quarterly to the commissioner beginning June 1, 2007, payments made during the second previous quarter that may qualify for reimbursement under federal law;

(2) based on these reports, the commissioner shall apply for federal matching funds. These funds are appropriated to the commissioner for the payments under section 256.969, subdivision 27; and

(3) by May 1 of each year, beginning May 1, 2007, the commissioner shall inform the nonstate entities listed in paragraph (a) of the amount of federal disproportionate share hospital payment money expected to be available in the current federal fiscal year.

(c) The commissioner shall apply for federal matching funds for general assistance medical care expenditures as follows:

(1) for hospital services occurring on or after July 1, 2007, general assistance medical care expenditures for fee-for-service inpatient and outpatient hospital payments made by the department shall be used to apply for federal matching funds, except as limited below:

(i) only those general assistance medical care expenditures made to an individual hospital that would not cause the hospital to exceed its individual hospital limits under section 1923 of the Social Security Act may be considered; and

(ii) general assistance medical care expenditures may be considered only to the extent of Minnesota's aggregate allotment under section 1923 of the Social Security Act; and

(2) all hospitals must provide any necessary expenditure, cost, and revenue information required by the commissioner as necessary for purposes of obtaining federal Medicaid matching funds for general assistance medical care expenditures.

(d) For the period from April 1, 2009, to September 30, 2010, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments under the American Recovery and Reinvestment Act of 2009. These funds shall be made available as the state share of payments under section 256.969, subdivision 28. The entities required to report certified public expenditures under paragraph (b), clause (1), shall report additional certified public expenditures as necessary under this paragraph.

(e) For services provided on or after July 1, 2011, the commissioner shall apply for additional federal matching funds available as disproportionate share hospital payments

under the MinnesotaCare program according to the requirements and conditions of paragraph (c).

Sec. 2. Minnesota Statutes 2010, section 256L.11, subdivision 6, is amended to read:

Subd. 6. **Enrollees 18 or older.** Payment by the MinnesotaCare program for inpatient hospital services provided to MinnesotaCare enrollees eligible under section 256L.04, subdivision 7, or who qualify under section 256L.04, subdivisions 1 and 2, with family gross income that exceeds 175 percent of the federal poverty guidelines and who are not pregnant, who are 18 years old or older on the date of admission to the inpatient hospital must be in accordance with paragraphs (a) and (b). Payment for adults who are not pregnant and are eligible under section 256L.04, subdivisions 1 and 2, and whose incomes are equal to or less than 175 percent of the federal poverty guidelines, shall be as provided for under paragraph (c).

(a) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is less than or equal to the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4. The hospital must not seek payment from the enrollee in addition to the co-payment. The MinnesotaCare payment plus the co-payment must be treated as payment in full.

(b) If the medical assistance rate minus any co-payment required under section 256L.03, subdivision 4, is greater than the amount remaining in the enrollee's benefit limit under section 256L.03, subdivision 3, payment must be the lesser of:

(1) the amount remaining in the enrollee's benefit limit; or

(2) charges submitted for the inpatient hospital services less any co-payment established under section 256L.03, subdivision 4.

The hospital may seek payment from the enrollee for the amount by which usual and customary charges exceed the payment under this paragraph. If payment is reduced under section 256L.03, subdivision 3, paragraph (b), the hospital may not seek payment from the enrollee for the amount of the reduction.

(c) For admissions occurring on or after July 1, 2011, for single adults and households without children who are eligible under section 256L.04, subdivision 7, the commissioner shall pay hospitals directly, up to the medical assistance payment rate, for inpatient hospital benefits up to the $10,000 annual inpatient benefit limit, minus any co-payment required under section 256L.03, subdivision 5. Inpatient services paid directly by the commissioner under this paragraph do not include chemical dependency hospital-based and residential treatment.

ARTICLE 16

MEDICAL ASSISTANCE PROVIDERS

Section 1. Minnesota Statutes 2010, section 256B.02, is amended by adding a subdivision to read:

Subd. 16. **Termination; terminate.** "Termination" or "terminate" for a provider means a state Medicaid program or state children's health insurance program has taken an action to revoke the provider's billing privileges, the provider has exhausted all appeal rights or the timeline for appeal has expired, there is no expectation by the provider, Medicaid program, or state children's health insurance program that the revocation is temporary, the provider will be required to reenroll to reinstate billing privileges, and the termination occurred for cause, including fraud, integrity, or quality.

Sec. 2. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision to read:

Subd. 4. **Prohibition on payments to providers outside of the United States.** Payments for medical assistance must not be made:

(1) for services delivered or items supplied outside of the United States; or

(2) to a provider, financial institution, or entity located outside of the United States.

Sec. 3. Minnesota Statutes 2010, section 256B.03, is amended by adding a subdivision to read:

Subd. 5. **Ordering or referring providers.** Claims for payments for supplies or services that are based on an order or referral of a provider or vendor must include the ordering or referring provider's national provider identifier (NPI). Claims for supplies or services ordered or referred by a vendor who is not enrolled in medical assistance are not covered.

Sec. 4. Minnesota Statutes 2010, section 256B.04, is amended by adding a subdivision to read:

Subd. 20. **Provider enrollment.** (a) The commissioner may impose temporary moratoria on enrollment of new providers, or impose numerical caps or other limits on categories of providers, subject to the following requirements:

(1) before imposing any moratoria, caps or limits, the commissioner must determine the action will not adversely impact beneficiaries' access to medical assistance;

(2) the commissioner may impose a moratorium for an initial period of six months. If necessary, the commissioner may extend the moratorium in six-month increments;

(3) the commissioner must announce the temporary moratorium and any subsequent extensions of a moratorium in a State Register document that must include the rationale for the imposition of the moratorium;

(4) the temporary enrollment moratorium does not apply to any enrollment application that has been submitted and is pending at the time moratorium is imposed; and

(5) the temporary enrollment moratorium does not apply to changes in practice location or supplier information such as phone number, address, or ownership.

(b) The commissioner may impose the temporary moratorium after obtaining concurrence from the Secretary of the United States Department of Health and Human Services if the commissioner determines that there is a significant potential for fraud, waste, or abuse.

(c) If the commissioner determines that there is a significant risk of fraudulent activity among a category of providers, the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(d) The commissioner shall require, as a condition of enrollment in medical assistance, that a provider or vendor within a particular industry sector or category establish a compliance program that contains the core elements established by the Center for Medicare and Medicaid Services.

(e) The commissioner may terminate the enrollment of an ordering or rendering provider if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider.

(f) The commissioner shall terminate or deny the enrollment of any individual or entity if such individual or entity has been terminated from participation in Medicare or in any other state's health care program.

(g)(1) A provider or vendor who submits an application for enrollment shall disclose any current or previous affiliation, direct or indirect, with a provider or vendor that has an unpaid debt to any state or federal health care program, has been or is subject to a payment suspension under a state or federal health care program, has been or is suspended, terminated, or excluded from participation in a state or federal health care program, or has had its billing privileges denied or revoked. "Affiliation" means a relationship where a

person or entity directly, or indirectly through one or more intermediaries, controls, or is controlled by, or is under common control with the provider or vendor.

(2) If the commissioner determines that a previous affiliation in clause (1) poses an undue risk of fraud, waste, or abuse, the commissioner may deny the application for enrollment. The commissioner may revoke enrollment of a provider if the commissioner determines that a provider failed to disclose an affiliation.

(h) As a condition of enrollment in medical assistance, the commissioner shall require that a provider or vendor permit CMS, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location.

(i) As a condition of enrollment in medical assistance, the commissioner shall require that a provider or vendor consent to criminal background checks, including fingerprinting, when required to do so under state law or by the level of screening based on risk of fraud, waste, or abuse as determined for that category of provider.

(j) The commissioner may terminate the enrollment of and exclude from participation any provider, vendor, or individual for making or causing to be made any false statement, omission, or misrepresentation of material fact in any application, agreement, or contract to participate or enroll as a provider or vendor. The commissioner may impose civil monetary penalties not to exceed $50,000 for the conduct described in this paragraph.

Sec. 5. Minnesota Statutes 2010, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following:

(1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance;

(2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary;

(3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled;

(4) suspension or termination as a Medicare vendor;

(5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment;

(6) failure to repay an overpayment finally established under this section; ~~and~~

(7) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act~~.~~; and

(8) knowingly making or causing to be made any false statement, omission, or misrepresentation of a material fact in any application, agreement, or contract to participate or enroll as a provider or vendor.

The determination of services not medically necessary may be made by the commissioner in consultation with a peer advisory task force appointed by the commissioner on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 5.

Sec. 6. Minnesota Statutes 2010, section 256B.064, subdivision 1b, is amended to read:

Subd. 1b. **Sanctions available.** The commissioner may impose the following sanctions for the conduct described in subdivision 1a: suspension or withholding of payments to a vendor; civil monetary penalties not to exceed $50,000; and suspending or terminating participation in the program. Regardless of imposition of sanctions, the commissioner may make a referral to the appropriate state licensing board.

Sec. 7. Minnesota Statutes 2010, section 256B.064, subdivision 2, is amended to read:

Subd. 2. **Imposition of monetary recovery and sanctions.** (a) The commissioner shall determine any monetary amounts to be recovered and sanctions to be imposed upon a vendor of medical care under this section. Except as provided in paragraphs (b) and (d), neither a monetary recovery nor a sanction will be imposed by the commissioner without prior notice and an opportunity for a hearing, according to chapter 14, on the commissioner's proposed action, provided that the commissioner may suspend or reduce payment to a vendor of medical care, except a nursing home or convalescent care facility, after notice and prior to the hearing if in the commissioner's opinion that action is necessary to protect the public welfare and the interests of the program.

(b) Except ~~for a nursing home or convalescent care facility,~~ when the commissioner finds good cause to suspend payments under Code of Federal Regulations, title 42, section 455.23(e) or (f), the commissioner ~~may~~ shall withhold or reduce payments to a vendor of medical care without providing advance notice of such withholding or reduction if either of the following occurs:

(1) the vendor is convicted of a crime involving the conduct described in subdivision 1a; or

(2) the commissioner ~~receives reliable evidence of fraud or willful misrepresentation by the vendor.~~ determines there is a credible allegation of fraud for which an investigation is pending under the program. A credible allegation of fraud is an allegation which has been verified by the state, from any source, including but not limited to:

(i) fraud hotline complaints;

(ii) claims data mining; and

(iii) patterns identified through provider audits, civil false claims cases, and law enforcement investigations.

Allegations are considered to be credible when they have an indicia of reliability and the state agency has reviewed all allegations, facts, and evidence carefully and acts judiciously on a case-by-case basis.

(c) The commissioner must send notice of the withholding or reduction of payments under paragraph (b) within five days of taking such action unless requested in writing by a law enforcement agency to temporarily withhold the notice. The notice must:

(1) state that payments are being withheld according to paragraph (b);

(2) set forth the general allegations as to the nature of the withholding action, but need not disclose any specific information concerning an ongoing investigation;

~~(2)~~ (3) except in the case of a conviction for conduct described in subdivision 1a, state that the withholding is for a temporary period and cite the circumstances under which withholding will be terminated;

~~(3)~~ (4) identify the types of claims to which the withholding applies; and

~~(4)~~ (5) inform the vendor of the right to submit written evidence for consideration by the commissioner.

The withholding or reduction of payments will not continue after the commissioner determines there is insufficient evidence of fraud ~~or willful misrepresentation~~ by the vendor, or after legal proceedings relating to the alleged fraud ~~or willful misrepresentation~~ are completed, unless the commissioner has sent notice of intention to impose monetary recovery or sanctions under paragraph (a).

(d) The commissioner ~~may~~ shall suspend or terminate a vendor's participation in the program without providing advance notice and an opportunity for a hearing when the suspension or termination is required because of the vendor's exclusion from participation in Medicare. Within five days of taking such action, the commissioner must send notice of the suspension or termination. The notice must:

(1) state that suspension or termination is the result of the vendor's exclusion from Medicare;

(2) identify the effective date of the suspension or termination; and

(3) inform the vendor of the need to be reinstated to Medicare before reapplying for participation in the program~~; and~~.

~~(4) inform the vendor of the right to submit written evidence for consideration by the commissioner.~~

(e) Upon receipt of a notice under paragraph (a) that a monetary recovery or sanction is to be imposed, a vendor may request a contested case, as defined in section 14.02, subdivision 3, by filing with the commissioner a written request of appeal. The appeal request must be received by the commissioner no later than 30 days after the date the notification of monetary recovery or sanction was mailed to the vendor. The appeal request must specify:

(1) each disputed item, the reason for the dispute, and an estimate of the dollar amount involved for each disputed item;

(2) the computation that the vendor believes is correct;

(3) the authority in statute or rule upon which the vendor relies for each disputed item;

(4) the name and address of the person or entity with whom contacts may be made regarding the appeal; and

(5) other information required by the commissioner.

Sec. 8. Minnesota Statutes 2010, section 256B.0641, subdivision 1, is amended to read:

Subdivision 1. **Recovery procedures; sources.** Notwithstanding section 256B.72 or any law or rule to the contrary, when the commissioner or the federal government determines that an overpayment has been made by the state to any medical assistance vendor, the commissioner shall recover the overpayment as follows:

(1) if the federal share of the overpayment amount is due and owing to the federal government under federal law and regulations, the commissioner shall recover from the medical assistance vendor the federal share of the determined overpayment amount paid to that provider using the schedule of payments required by the federal government;

(2) if the overpayment to a medical assistance vendor is due to a retroactive adjustment made because the medical assistance vendor's temporary payment rate was higher than the established desk audit payment rate or because of a department error in calculating a payment rate, the commissioner shall recover from the medical assistance vendor the total amount of the overpayment within 120 days after the date on which written notice of the adjustment is sent to the medical assistance vendor or according to a schedule of payments approved by the commissioner; ~~and~~

(3) a medical assistance vendor is liable for the overpayment amount owed by a long-term care provider if the vendors or their owners are under common control or ownership.; and

(4) in order to collect past due obligations to the department, the commissioner shall make any necessary adjustments to payments to a provider or vendor that has the same tax identification number as is assigned to a provider or vendor with past due obligations.

Sec. 9. Minnesota Statutes 2010, section 256B.27, subdivision 3, is amended to read:

Subd. 3. **Access to medical records.** The commissioner of human services, with the written consent of the recipient, on file with the local welfare agency, shall be allowed access to all personal medical records of medical assistance recipients solely for the purposes of investigating whether or not: ~~(a)~~ (1) a vendor of medical care has submitted a claim for reimbursement, a cost report or a rate application which is duplicative, erroneous, or false in whole or in part, or which results in the vendor obtaining greater compensation than the vendor is legally entitled to; or ~~(b)~~ (2) the medical care was medically necessary. ~~The vendor of medical care shall receive notification from the commissioner at least 24 hours before the commissioner gains access to such records.~~ The determination of provision of services not medically necessary shall be made by the commissioner. The commissioner may consult with an advisory task force of vendors the commissioner may appoint, on the recommendation of appropriate professional organizations. The task force expires as provided in section 15.059, subdivision 6. Notwithstanding any other law to the contrary, a vendor of medical care shall not be subject to any civil or criminal liability for providing access to medical records to the commissioner of human services pursuant to this section.

ARTICLE 17

NONEMERGENCY MEDICAL TRANSPORTATION

Section 1. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 56. **Nonemergency medical transportation advisory committee.** (a) The commissioner shall establish a nonemergency medical transportation advisory committee. The nonemergency medical transportation advisory committee shall advise the commissioner regarding the creation of a single administrative structure for the coordination and management of nonemergency medical transportation services provided under this chapter.

(b) Members must include, but are not limited to, representatives from the following: Departments of Human Services and Transportation; Association of Minnesota Counties; Metropolitan Council; ARC of Minnesota; Minnesota State Council on Disabilities; transportation providers; managed care plans; skilled nursing facilities; and the National Alliance on Mental Illness. The commissioner shall submit a proposal with draft legislation to the legislature by January 15, 2012.

ARTICLE 18

MANAGED CARE REPORTING

Section 1. Minnesota Statutes 2010, section 13.461, subdivision 24a, is amended to read:

Subd. 24a. **Managed care plans.** Data provided to the commissioner of human services by managed care plans relating to contracts and provider payment rates are classified under section 256B.69, ~~subdivisions~~ subdivision 9a ~~and 9b~~.

Sec. 2. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data as determined by the commissioner and managed care and county-based purchasing plans that are required to be submitted under this section. The commissioner, in consultation with the commissioners of health and commerce, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data under this section.

(b) Each managed care and county-based purchasing plan must annually provide to the commissioner, in the form and manner specified by the commissioner:

(1) administrative expenses by category and subcategory, by program;

(2) revenues by program, including investment income;

(3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including health care home and total cost of care rate methodologies and other provider total cost or risk-based arrangements;

(iii) data on legislatively mandated provider rate changes; and

(iv) plan-specific provider rate methodologies and individual-level or disaggregated data provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(4) data on the amount of reinsurance or transfer of risk by program; and

(5) contribution to reserve, by program.

(c) Section 62U.04, subdivision 4, paragraph (b), does not apply to the commissioners of health and human services for the purposes of administering state public programs.

Sec. 3. **REPEALER.**

Minnesota Statutes 2010, section 256B.69, subdivision 9b, is repealed.

APPENDIX
Article locations in 11-0152