A bill for an act

relating to health; requiring health insurance coverage of durable medical equipment to include coverage of items necessary to reduce asthma symptoms; requiring state health care program coverage of certain items necessary to reduce asthma symptoms; amending Minnesota Statutes 2008, sections 62Q.66; 256B.0625, subdivision 31; 256D.03, subdivision 4.

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

Section 1. Minnesota Statutes 2008, section 62Q.66, is amended to read:

62Q.66 DURABLE MEDICAL EQUIPMENT COVERAGE.

(a) No health plan company that covers durable medical equipment may utilize medical coverage criteria for durable medical equipment that limits coverage solely to equipment used in the home.

(b) A health plan that covers durable medical equipment must include coverage of the following items if necessary to reduce asthma symptoms: high efficiency particulate air (HEPA) cleaners, HEPA vacuum cleaners, allergy bed and pillow encasements, high filtration filters for forced air gas furnaces, and dehumidifiers with medical tubing to connect the appliance to a floor drain.

EFFECTIVE DATE. This section is effective August 1, 2009, and applies to health plans offered, issued, sold, renewed, or continued as defined in section 60A.02, subdivision 2a, on or after that date.

Sec. 2. Minnesota Statutes 2008, 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.

(b) Medical assistance coverage of durable medical equipment includes, but is not limited to: high efficiency particulate air (HEPA) cleaners, HEPA vacuum cleaners, allergy bed and pillow encasements, high filtration filters for forced air gas furnaces, and dehumidifiers with medical tubing to connect the appliance to a floor drain, if the listed item is necessary to reduce asthma symptoms.

Sec. 3. Minnesota Statutes 2008, section 256D.03, subdivision 4, is amended to read:

Subd. 4. **General assistance medical care; services.** (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

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

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

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

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services as covered under the medical assistance program;

(15) mental health services covered under chapter 256B;

(16) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(17) medical supplies and equipment, including items necessary to treat asthma symptoms as listed in section 256B.0625, subdivision 31, paragraph (b), and Medicare premiums, coinsurance and deductible payments;

(18) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(19) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(20) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171;

(21) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b;

(22) care coordination and patient education services provided by a community health worker according to section 256B.0625, subdivision 49; and

(23) regardless of the number of employees that an enrolled health care provider may have, sign language interpreter services when provided by an enrolled health care provider during the course of providing a direct, person-to-person covered health care service to an enrolled recipient who has a hearing loss and uses interpreting services.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Effective August 1, 2005, sex reassignment surgery is not covered under this subdivision.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by

counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Effective January 1, 2008, drug coverage under general assistance medical care is limited to prescription drugs that:

(i) are covered under the medical assistance program as described in section 256B.0625, subdivisions 13 and 13d; and

(ii) are provided by manufacturers that have fully executed general assistance medical care rebate agreements with the commissioner and comply with the agreements. Prescription drug coverage under general assistance medical care must conform to coverage under the medical assistance program according to section 256B.0625, subdivisions 13 to 13g.

(e) Recipients eligible under subdivision 3, paragraph (a), shall pay the following co-payments for services provided on or after October 1, 2003, and before January 1, 2009:

(1) $25 for eyeglasses;

(2) $25 for nonemergency visits to a hospital-based emergency room;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(4) 50 percent coinsurance on restorative dental services.

(f) Recipients eligible under subdivision 3, paragraph (a), shall include the following co-payments for services provided on or after January 1, 2009:

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

(2) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $7 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness.

(g) MS 2007 Supp [Expired]

(h) Effective January 1, 2009, co-payments shall be limited to one per day per provider for nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $7 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment.

(i) General assistance medical care reimbursement to fee-for-service providers and payments to managed care plans shall not be increased as a result of the removal of the co-payments effective January 1, 2009.

(j) Any county may, from its own resources, provide medical payments for which state payments are not made.

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

(l) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

(m) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

(n) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (l).

(o) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

(p) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

(q) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

(r) Fee-for-service payments for nonpreventive visits shall be reduced by $3 for services provided on or after January 1, 2006. For purposes of this subdivision, a visit

means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, advance practice nurse, audiologist, optician, or optometrist.

(s) Payments to managed care plans shall not be increased as a result of the removal of the $3 nonpreventive visit co-payment effective January 1, 2006.

(t) Payments for mental health services added as covered benefits after December 31, 2007, are not subject to the reductions in paragraphs (l), (n), (o), and (p).