Bill Summary Comparison of

Health and Human Services

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| Senate File 1458 | Senate File 1458, 1st Unofficial Engrossment |
| Article 10: Health Care | Articles 1 & 2: Health Care and MinnesotaCare |

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| Article 10: Health Care |  | Articles 1 & 2: Health Care and MinnesotaCare |
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| Section 1 (16A.724, subd. 2) makes MinnesotaCare a forecasted program. | Senate only provision |  |
| **Section 2 (62A.045)** Paragraph (f) requires a health insurer to process a clean claim from a state agency for covered expenses paid under state medical programs within 90 days. Requires an insurer to pay all other claims within the timeline set forth in federal regulations.  Paragraph (g) permits an insurer to request a refund of a claim paid in error to DHS within two years of the date the payment was made to DHS. Specifies that a request for a refund made after that time period will not be honored. | House adds a sentence in paragraph (f) that states if an insurer needs additional information to process a claim, the insurer may be granted an additional 30 business days after insurer receives claim. Senate requires claims other than clean claims to be processed according to federal timelines. Otherwise identical. | Article 1, § 1. Payments on behalf of enrollees in government health programs. Amends § 62A.045. A new paragraph (f) requires health insurers to process third-party liability claims from the state within 90 business days of claim submission. If the health insurer needs more information to process the claim, allows the insurer an additional 30 business days to process the claim, if the insurer submits the request for additional information within 30 business days of receiving the claim.  A new paragraph (g) allows health insurers to request refunds from DHS for claims paid in error within two years of the date of payment to DHS. Provides that a request for a refund will not be honored once this time period has lapsed. |
|  | House only provision | Article 1, § 2. Resident dentists. Amends § 150A.06, subd. 1b. Provides that a University of Minnesota School of Dentistry dental resident holding a resident dental license is eligible for enrollment in MA under section 250B.0625, subd. 9b. |
| **Section 3 (174.29, subd. 1)** **Effective July 1, 2016,** adds certain nonemergency medical transportation services to the definition of special transportation services. | Senate only provision |  |
| **Section 4 (174.30, subd. 3)** **Effective July 1, 2016,** requires the Commissioner of Transportation to inspect the safety features required in vehicles designated as protected transport under nonemergency medical transportation services under section 256B.0625, subdivision 17. | Senate only provision |  |
| **Section 5 (174.30, subd. 4, paragraph (e))** **Beginning July 1, 2016,** requires certain nonemergency medical transportation providers and special transportation service providers to pay a $45 annual fee to obtain a decal signifying possession of a certificate of compliance with the operating standards for special transportation services, and exempts ambulance services from this fee. The revenue from the fee is appropriated to the Commissioner of Transportation to pay for the inspection program.  **Paragraph (g)** permits nonemergency medical transportation providers to use the phrase “nonemergency medical transportation” in their name, advertisements or information describing their service, thereby exempting nonemergency medical transportation providers from a Minnesota Rule that prohibits special transportation service providers from using in their name, advertisements, or information describing their service, any words that offer, suggest, or imply they provide ambulance service. | Senate only provision |  |
| **Section 6 (174.30, subd. 4b)** permits the Commissioner of Transportation to issue a variance from the operating standards for special transportation services to nonemergency medical transportation providers who were not subject to the operating standards prior to July 1, 2014. Providers may apply for a variance if they will not be able to meet the operating standards within six months following the enactment of this subdivision.  No variance may exceed 60 days, unless extended by the commissioner. | Senate only provision |  |
| **Section 7 (174.30, subd. 10)** **Paragraphs (a) and (b)** require a provider of special transportation services (STS) to initiate background studies on its employees using the online NETStudy system operated by the Commissioner of Human Services.  **Paragraph (c)** prohibits an STS provider from allowing an employee to provide services unless the employee passes a background study.  **Paragraph (d)** permits a local or contracting agency to initiate background studies of volunteer drivers who provide nonemergency medical transportation services. | Senate only provision |  |
| **Section 8 (245C.03, subd. 10)** requires DHS to conduct background studies for providers of special transportation services who initiate the studies of their employees, as they are required to do under Minnesota Statutes, section 174.30, subdivision 10. | Senate only provision |  |
| **Section 9 (245C.10, subd. 11**) imposes on special transportation providers a fee of no more than $20 per background study.  Appropriates the fee to the commissioner to conduct the background studies. | Senate only provision |  |
| **Section 10 (256.015, subd. 7)** requires an employer or third-party payer to provide DHS, within 60 days of a request, the following information as part of the data file:  name, date of birth, Social Security number, if number is collected and stored in a system routinely used for producing data, employer name, policy identification number, group identification number, and plan or coverage type. | Senate only provision |  |
| **Section 11 (256.969, subd. 1)** eliminates the requirement that MMB submit budget change requests for annual adjustments to hospital payment rates. | Senate only provision |  |
| **Section 12 (256.969, subd 2b)** **Paragraph (d)** extends the five percent banding that expires June 30, 2016, until the next rebasing, but only for hospitals paid on a diagnosis-related group (DRG) methodology.  **Paragraph (e)** extends until the next rebasing the additional adjustments to the rebased hospital payment rates that were set to expire on June 30, 2016.  **Paragraph (i)** grants DHS the authority to determine a new methodology for determining a cost-based final payment rate for critical access hospitals, but no hospital may receive less than 95 percent of its base year payment. | Paragraphs (d) and (e) Senate only  Paragraph (i) identical, except Senate prohibits until the next rebasing any hospital from receiving less than 95 percent of its base year payment. | Article 1, § 5. Hospital payment rates. Amends § 256.969, subd. 2b. Requires payment rates for critical access hospitals located in Minnesota or the local trade area to be determined using a new cost-based methodology, effective for discharges on or after July 1, 2015. Requires the commissioner to include in the methodology tiers of payment to promote efficiency and cost-effectiveness. Specifies other requirements for the methodology and lists factors to be used to develop the new methodology. |
| **Section 13 (256.969, subd. 3a)**specifies that beginning July 1, 2015, individual hospital payment rate adjustments for fee-for-service to long-term care hospitals and rehabilitation hospitals for inpatient services must be incorporated into the hospital’s payment rate and not applied to each claim. | Senate only provision |  |
| **Section 14 (256.969, subd. 3c)**specifies that beginning July 1, 2015, the ten percent buy-back for fee-for-service inpatient services at long-term care hospitals and rehabilitation hospitals must be incorporated into the hospital’s payment rate and not applied to each claim. | Senate only provision |  |
| **Section 15 (256.969, subd. 9)** grants DHS the authority to determine a new methodology for determining the disproportionate share hospital payment rate. | In paragraph (a), Senate removes authority for commissioner to establish a separate DSH adjustment for critical access hospitals; House does not include this language.  In paragraph (d), House language includes a greater number of factors to be accounted for in a new DSH payment rate methodology (clauses 3, 4, and 5). In paragraph (e), Senate sets specific criteria for redistribution of DSH funding; House leaves this to discretion of commissioner. | Article 1, § 6. Disproportionate numbers of low-income patients served. Amends § 256.969, subd. 9. Requires disproportionate share hospital (DSH) payments to be paid according to a new methodology, effective July 1, 2015. Requires annual DSH payments under the new methodology to equal the total amount of DSH payments made for 2012. Lists factors that the methodology must take into account. Requires payments returned to the commissioner because they exceed the hospital-specific DSH limit for a hospital to be redistributed to other DSH-eligible hospitals in a manner established by the commissioner. |
|  | House only provision | Article 2, § 1. Wrongfully obtaining assistance. Amends § 256.98, subd. 1. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date. |
|  | House only provision | Article 2, § 2. Projects. Amends § 256B.021, subd. 4. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date. |
| **Section 16 (256B.06, subd. 6)** requires the commissioner to award grants to nonprofit programs that provide legal services based on indigency to provide legal services to individuals with emergency medical conditions or chronic health conditions who are not currently eligible for medical assistance due to their legal status, but may meet eligibility requirements with legal assistance. | Senate only provision |  |
| **Section 17 (256B.0625, subd. 9)** modifies the adult dental services covered under medical assistance by covering a full-mouth series of x-rays or panoramic x-rays; covering nonsurgical treatment for periodontal disease limited to once a year; and covering a comprehensive oral exam and full-mouth series of x-rays as part of outpatient dental surgery. | Senate only provision |  |
| **Section 18 (256B.0625, subd. 9b)** authorizes a dentist who is not a medical assistance provider, and who is either a faculty or adjunct member at the University of Minnesota Dental School or a dental resident to be enrolled as a medical assistance provider for purposes of providing dental services at the University of Minnesota Dental School clinic if the provider submits an agreement form to the commissioner. | Identical | Article 1, § 8. Dental services provided by faculty members and resident dentists at a dental school. Amends § 256B.0625, by adding subd. 9b. (a) Allows a dentist who is not enrolled as an MA provider, is on the faculty or an adjunct member at the University of Minnesota or is a resident dentist, and is providing dental services at a dental clinic owned or operated by the University of Minnesota, to be enrolled as an MA provider, if the dentist completes and submits to the commissioner an agreement form. Requires the agreement to specify that the individual:  (1) will not receive payment for services provided to MA or MinnesotaCare enrollees at University of Minnesota dental clinics;  (2) will not be listed in the MA or MinnesotaCare provider directory; and  (3) is not required to serve MA and MinnesotaCare enrollees when providing nonvolunteer services in a private practice.  (b) Provides that an individual enrolled under this subdivision as a fee-for-service provider shall not otherwise be enrolled in or receive payments from MA or MinnesotaCare as a fee-for-service provider. |
| **Section 19 (256B.0625, subd. 9c)** specifies that the following prior authorizations (PA) for dental services shall apply: (1) a PA must remain valid for at least 12 months; (2) a new PA is not required if a PA for the service has already been provided within the previous 12 months for the same enrollee if the enrollee changes health plans within the 12-month period; and (3) a managed care plan or county-based purchasing plan shall not require a PA that is more restrictive than the PA requirements in place in the fee-for-service system. | Senate only provision |  |
| **Section 20 (256B.0625, subd. 9d**) requires the commissioner to designate a uniform application form to be used in the credentialing of all dental providers serving persons enrolled in medical assistance and MinnesotaCare. | Senate only provision |  |
| **Section 21 (256B.0625, subd. 13h)** expands medication therapy services covered by MA to recipients taking prescriptions to treat or prevent one or more chronic medical conditions.  Also permits medication therapy management services to be delivered into patient’s residence via secure interactive video if the services are performed electronically during a covered home visit by an enrolled provider.  States that reimbursement shall be at the same rate and same condition as would otherwise apply and the pharmacist providing the services must be located within an ambulatory setting that meets specified requirements. | Identical | Article 1 § 11. Medication therapy management services. Amends § 256B.0625, subd. 13h. The amendment to paragraph (a) modifies eligibility criteria for MA coverage of medication therapy management services, by eliminating the requirement that a recipient be taking three or more prescriptions, and making related changes. The amendment to paragraph (c) eliminates a reference to the GAMC program. The amendment to paragraph (d) clarifies the requirement that a pharmacist providing medication therapy management services by interactive video be located within an ambulatory setting. The amendment to paragraph (e) eliminates obsolete language related to a pilot project and authorizes the provision of medication therapy management delivered into a patient’s residence by interactive video. |
| **Section 22 (256B.0625, subd. 14)** specifies that medical assistance covers as a part of screening services oral health screenings that are performed by a dental hygienist, dental therapist, or advanced dental therapist in a collaborative practice  to determine an enrollee’s need to be seen by a dentist for diagnosis, assessment, or referral for treatment.  The oral screenings are limited to once a year and the provider performing the screening must have an agreement in place that refers to those needing follow-up care to a licensed dentist. | Senate only provision |  |
| **Section 23 (256B.0625, subd. 17)** creates **effective July 1, 2016,** a new rate structure for nonemergency medical transportation and thereby implements the new modes of transportation placed in statute in 2014, implementation of which was contingent on a new rate structure.  **Paragraph (f)** eliminates the rate structure for special transportation services provided to eligible persons who need a wheelchair accessible van; and reorganizes the paragraph.  **Old paragraph (g)** eliminates redundant language contained in paragraph h.  **New paragraph (g)** permits acquaintances of a client to receive client reimbursement for providing qualifying transportation to the client and moves language concerning protected transport to clause (6).  **Paragraph (i)** clarifies that local agencies will assume responsibility for administering the nonemergency medical transportation program only after the commissioner has developed, made available, and funded the single administrative structure and delivery system described under section 256B.0625, subdivision 18e, but limits counties' financial obligations.  **Paragraph (l)** creates a new rate structure for nonemergency medical transportation based on a client’s assessed mode of transportation.  **Paragraph (m)** provides adjustments to the base rate for services provided in super rural areas and to the mileage rates for services provided in rural and super rural areas.  **Paragraph (n)** makes technical and conforming changes.  **Old paragraph (o)** strikes a rate decrease for nonemergency medical transportation. | House language contains only the provision in paragraph (i) related to county financial obligations (this language is identical). | Article 1, § 12. Transportation costs. Amends § 256B.0625, subd. 17. Provides that the local agency shall be the single administrative agency and shall administer and reimburse for nonemergency medical transportation service modes, when the commissioner has developed, made available, and funded the Web-based single administrative structure, assessment tool, and level of need assessment. States that the financial obligation of the local agency is limited to the funds provided by the state or federal government. |
| **Section 24 (256B.0625, subd. 17a)** strikes a rate decrease for ambulance services effective July 1, 2016. | Senate only provision |  |
| **Section 25 (256B.0625, subd. 18a)** strikes language concerning direct mileage reimbursement that is replaced by the client reimbursement language in section 256B.0625, subdivision 17, paragraph (l), effective July 1, 2016. | Senate only provision |  |
| **Section 26 (256B.0625, subd. 18e)** requires the Commissioner of Human Services to coordinate with the Commissioner of Transportation in developing the single administrative structure and delivery system for nonemergency medical transportation. | Senate only provision |  |
|  | House only provision | Article 1, § 13. Licensed physician assistant services. Amends § 256B.0625, subd. 28a. Allows licensed physician assistants meeting specified criteria, who have completed 2,000 hours of clinical experience in the evaluation and treatment of mental health, to bill for medication management and evaluation and management services provided to MA enrollees in outpatient settings. (Under current law, billing by physician assistants meeting specified criteria is limited to inpatient hospital settings, and 2,000 hours of clinical experience is not required.) |
| **Section 27 (256B0625, subd. 31)** permits the commissioner to set reimbursement rates for specialized categories of medical supplies at a level below the Medicare payment rate. | Identical | Article 1, § 14. Medical supplies and equipment. Amends § 256B.0625, subd. 31. Strikes language allowing the commissioner to set MA payment rates for specified categories of medical supplies at levels below the Medicare payment rate. |
| **Section 28 (256B.0625, subd. 57)** excludes payments to federally qualified health centers and rural health centers from the Medicare cost-sharing payment limitation. | Senate only provision |  |
| **Section 29 (256B.0625, subd. 58)** specifies that payment for providing an EPSDT screening shall not include charges for health care services and products that are available to the provider at no cost. | Identical | Article 1, § 15. Early and periodic screening, diagnosis, and treatment services. Amends § 256B.0625, subd. 58. Prohibits payment under an EPSDT screening for health care services and products that are available at no cost to the provider (the restriction in current law is related to vaccines available at no cost). |
| **Section 30 (256B.0631)** makes changes to the MA co-payments to conform to changes in federal regulations. | Identical | Article 1, § 16. Medical assistance co-payments. Amends § 256B.0631. The amendment to subdivision 1 specifies that the family deductible is $2.75 per month per family and is to be adjusted annually. The amendment also applies the limit on monthly cost-sharing to 5 percent of income to all MA enrollees (current law applies this to enrollees with incomes at or below 100 percent of FPG), and states that this limit does not apply to premiums charged to persons eligible for MA as employed persons with disabilities.  The amendment to subdivision 2 provides that copayments and deductibles do not apply to: (1) American Indians who are eligible to receive, or have received, services from an Indian health care provider or through referral; (2) persons eligible for MA because they need treatment for breast or cervical cancer; and (3) certain preventive services, immunizations, and screenings.  The amendment to subdivision 3 makes a conforming change related to the 5 percent cost-sharing limit.  States that the establishment of the family deductible at $2.75 is effective retroactively from January 1, 2014. |
| **Subd. 1** modifies the family deductible amount to keep the deductible at $2.75 per month per family and permits it to be adjusted annually by the percentage in the medical care component of the CPI-U.  Also specifies that family deductible does not apply to premiums charged to individuals enrolled in MA-EPD. | Identical |  |
| **Subd. 2** exempts from co-payments and deductibles: American Indians who are enrolled in a federally recognized tribe; individuals eligible for MA through the breast and cervical cancer control program; and preventive health services recommended by the U.S. Preventive Services Task Force. | Identical |  |
| **Subd. 3** caps cost-sharing for all MA recipients at five percent of the family’s income. | Identical |  |
| **Section 31 (256B.0638)** creates the opioid prescribing improvement program. | Senate only provision |  |
| **Subd. 1** requires the Commissioners of Human Services, in conjunction with the Commissioner of Health, to establish a statewide opioid prescribing program to reduce opioid dependency and substance use due to the prescribing of opioid analgesics by health care providers. |  |  |
| **Subd. 2** defines terms. |  |  |
| **Subd. 3** requires the Commissioner of Human Services, in consultation with the Commissioner of Health, to establish an opioid prescribing work group. |  |  |
| **Subd. 4** requires the work group to recommend to the commissioners the components of the statewide opioid prescribing improvement program, including criteria for opioid prescribing protocols; developing sentinel measures; educational resources for opioid prescribers about pain management and the use of opioids to treat pain; opioid quality improvement standard thresholds and opioid disenrollment standards for opioid prescribers and provider groups; and other program issues as determined by the commissioners. |  |  |
| **Subd. 5.**  **Paragraph (a)** requires the Commissioner of Human Services to implement the program and to annually collect and report to opioid prescriber’s data showing the sentinel measures of their opioid prescribing patterns compared to their anonymized peers.  **Paragraph (b)** requires the commissioner to notify the prescriber and all provider groups with which the prescriber is employed or affiliated when the prescriber’s prescribing pattern exceeds the opioid quality improvement standards thresholds.  If notified by the commissioner, the prescriber is required to submit to the commissioner a quality improvement plan for review and approval.  **Paragraph (c)** specifies that if after one year the prescriber’s prescribing practices are not consistent with community standards, the commissioner may take certain steps.  **Paragraph (d)** requires the commissioner to disenroll from the Minnesota health care programs all prescribers and provider groups whose prescribing practices fall within the applicable opioid disenrollment standards. |  |  |
| **Subd. 6** classifies the reports and data identifying an opioid prescriber as private data on individuals until the prescriber is subject to disenrollment as a MA provider, then permits the commissioner to share with all the provider groups with which the prescriber is employed or affiliated a report identifying the prescriber.  Specifies that data and reports identifying a provider group are nonpublic data until the provider group is subject to disenrollment.  At that time the data and reports are public, except that any identifying information of enrollees must be redacted by the commissioner. |  |  |
| **Subd. 7** requires the commissioner to annually report to the legislature on the status of the implementation of the program, including data on utilization of opioids in the Minnesota health care programs. |  |  |
|  | House only provision | Article 1, § 17. Reimbursement under other state health care programs. Amends § 256B.0644. Exempts dental services providers providing dental services outside the seven-county metropolitan area from the state health care program participation requirement. Provides that the section is effective upon receipt of any necessary federal waiver or approval. |
| **Section 32 (256B.0757)** expands the certification of health homes to include behavioral health homes. | Senate only provision |  |
| **Subd. 1** requires the commissioner to establish behavioral health homes to serve individuals with serious mental illness.  Requires the services provided by these behavioral health homes to focus on both behavioral and physical health. |  |  |
| **Subd. 2** expands who is eligible for health home services to include individuals who have been diagnosed with a mental illness. |  |  |
| **Subd. 4** specifies that health home services are voluntary and that an eligible individual may choose any designated provider.  Defines a designated provider as a clinical practice or clinical group practice, rural clinic, community health center, community mental health center, or another entity that is determined by the commissioner to be qualified to be a health home. |  |  |
| **Subd. 5** clarifies that the commissioner shall make payments to each designated provider for the provision of health home services. |  |  |
| **Subd. 6** changes terminology to refer to designated providers. |  |  |
| **Subd. 8** requires health homes to meet process, outcome, and quality standards developed and specified by the commissioner.  Requires the commissioner to collect data from health homes to monitor compliance with certification standards. Permits the commissioner to contract with a private entity to evaluate patient and family experiences, health care utilization, and costs.  Requires the commissioners to utilize findings from the utilization of health homes to determine populations to serve under subsequent health home models for individuals with chronic conditions. |  |  |
| **Section 33 (256B.0758)** permits the commissioner to establish a health care delivery pilot program to test integrated health care delivery networks created by or including North Memorial Health Care. | Senate adds a paragraph (d) that requires the commissioner to report to the legislature on whether a delivery network was created by North Memorial, a description of the system, and the geographic area served by the system. Otherwise identical. | Article 1, § 18. Health care delivery pilot program. Adds § 256B.0758. (a) Allows the commissioner of human services to establish a health care delivery pilot program to test alternative and innovative health care delivery networks. These may include accountable care organizations or a community-based collaborative care networks created by, or including, North Memorial Health Care. Directs the commissioner, if required, to seek federal waiver approval, or amend an existing demonstration pilot project waiver.  (b) Provides that individuals eligible for the pilot program must be eligible for MA. Allows the commissioner to identify individuals for the pilot program based on zip code or whether the individuals would benefit from an integrated health care delivery network.  (c) Requires the commissioner, in developing the payment system for the pilot program, to establish a total cost of care for enrolled individuals that equals the cost of care that would otherwise be spent under the prepaid medical assistance program. |
| **Section 34 (256B.69, subd. 5a)** requires managed care and county-based purchasing plans to maintain current and fully executed agreements for all subcontractors, including bargaining groups for administrative services that are expensed to the state’s public health care programs.  Subcontractor agreements over $200,000 in annual payments must be in a form of a written instrument or electronic document and must contain specific elements and must clearly indicate how they relate to state public health care programs. Provides the commissioner, upon request, with access to all subcontractor documentation under this paragraph. | Identical, except for technical differences (staff recommend Senate) | Article 1, § 19. Managed care contracts. Amends § 256B.69, subd. 5a. Requires managed care plans and county-based purchasing plans to maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services expensed to state public programs. Requires subcontractor agreements of over $200,000 in annual payments to be in the form of a written instrument or electronic document and meet specified requirements. Allows the commissioner, upon request, to have access to all subcontractor documentation. Provides that the paragraph does not allow the release of nonpublic information. |
| **Section 35 (256B.69, subd. 5i) Paragraph (a)** specifies that administrative costs paid to managed care plans or county-based purchasing plans must not exceed 6.6 percent of total payments to all managed care and county-based purchasing plans in aggregate across all state public health care programs based on payments to be made at the beginning of each calendar year.  Authorizes the commissioner to eliminate or reduce administrative requirements to meet the administrative cost limit.  Excludes state or federal taxes, surcharges, or assessments.  **Paragraph (b)** specifies the expenses that are not allowable administrative expenses for rate-setting purposes.  **Paragraph (c)** requires administrative expenses to be reported using the formats designated by the commissioner as part of the rate setting process and specifies the categories to be included.  **Paragraph (d)** requires the commissioner to reduce administrative expenses paid to managed care plans and county-based purchasing plans by .56 of a percentage point for contracts beginning January 1, 2016, and ending December 31, 2017; and by .77 of a percentage point for contracts beginning January 1, 2018, and ending December 31, 2019. | Difference in phrasing in paragraph (a); same intent.  House in (b)(2) excludes medical directors from the $200,000 cap; Senate does not.  Senate in (d) requires the commissioner to reduce plan administrative expenses by .56 of a percentage point beginning January 1, 2016, and by .77 of a percentage point beginning January 1, 2018.  House in (d) applies the subdivision requirement to integrated health partnerships; Senate does not.  In paragraph (b), Senate refers to managed care and county-based purchasing plans in the list of what is included as a contribution; House to HMO’s.  Senate throughout refers to public “health care” programs; House to public programs (staff recommend Senate). | Article 1, § 20. Administrative expenses. Amends § 256B.69, subd. 5i. The amendment to paragraph (a) limits managed care and county-based purchasing plan administrative costs to 6.6 percent of total managed care payments in the aggregate for all state public programs, and specifies related criteria. The provision replaces a provision in current law that limits the growth in administrative costs to 5 percent (measured by the ratio of administrative spending to total revenue).  The amendment to paragraph (b) clarifies existing not allowable administrative expenses, and adds additional not allowable administrative expenses.  A new paragraph (c) requires plans to report administrative expenses using the formats designated by the commissioner as part of the rate-setting process, and specifies categories and other requirements. Also requires plans to identify and record expense items for public program administrative expenses in a manner that allows independent verification of unallowable expenses for purposes of determining state public health care program payment rates.  A new paragraph (d) applies the administrative expenses requirements of the subdivision to demonstration providers under section 256B.0755. |
| **Section 36 (256B.69, subd. 9c)** requires managed care plans and county-based purchasing plans to certify to the commissioner, for purposes of financial reporting, that costs reported for state public health care programs, including only services covered under the state plan and waivers and related allowable expenses; and the dollar value of unallowable and nonstate plan services that have been excluded. | Paragraph (d) is similar, with differences in formatting.  House in (e) applies requirements to integrated health partnerships; Senate does not. | Article 1, § 21. Managed care financial reporting. Amends § 256B.69, subd. 9c. Requires managed care and county-based purchasing plans to certify to the commissioner, for purposes of state public health care program financial reporting, that costs reported for state public health care programs include only services covered under the state plan and waivers, and related allowable administrative expenses. Also requires plans to certify and report to the commissioner the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, for purposes of managed care financial reporting. Applies the requirements of this subdivision to demonstration providers under section 256B.0755. |
| **Section 37 (256B.69, subd. 9d)** modifies the current financial audits to require managed care plans and county-based purchasing plans to submit to and cooperate with the independent third- party financial audits by the legislative auditor.  Authorizes the commissioner to conduct ad hoc audits of the state public health care programs administrative and medical expenses of managed care plans and county-based purchasing plans. | House applies requirements to integrated health partnerships; Senate does not.  Technical differences (staff recommend Senate) | Article 1, § 22. Financial and quality assurance audits. Amends § 256B.69, subd. 9d. A new paragraph (e) allows the commissioner to conduct ad hoc audits of managed care organization administrative and medical expenses. Specifies expense categories and audit procedures.  Amendments to various paragraphs strike the requirement in current law that the legislative auditor contract with an audit firm for biennial independent third-party financial audits and make related changes. Revised language related to audits by the legislative auditor is added in section 256B.69, subd. 9e.  A new paragraph (g) applies the audit requirements of this subdivision to demonstration providers under section 256B.0755.  Also makes technical and clarifying changes. |
| **Section 38 (256B.69, subd. 9e)** requires the legislative auditor to contract with vendors to conduct independent third-party financial audits of the information required to be provided by managed care plans and county-based purchasing plans. | House applies audits to DHS; Senate to data provided by plans. Otherwise identical. | Article 1, § 23. Financial audits. Amends § 256B.69, by adding subd. 9e. Requires the legislative auditor to contract with vendors to conduct independent third-party financial audits of DHS’s use of the information provided by managed care and county-based purchasing plans. Provides that the audits shall be conducted as vendor resources permit and specifies other requirements. Requires the audits to include a determination of DHS’s compliance with the federal Medicaid rate certification process. Provides a definition of “independent third-party” (this definition does not include requirements related to licensure as an accounting firm, and not having provided services to a plan during the audit period, that are in the current law stricken in subdivision 9d). |
| **Section 39 (256B.695)** establishes dental services utilization measures. | Senate only provision |  |
| **Subd. 1** requires the commissioner to evaluate access to dental services for children and adults in medical assistance and MinnesotaCare using the following:   1. the percentage of enrollees that have access to nonspecialty dental services within a 60-minute or 60-mile radius of the enrollee’s residence; 2. the percentage of adult enrollees continuously enrolled for 6 months in a calendar year receiving an oral evaluation within the year; and 3. the percentage of children under the age of 21 continuously enrolled for at least 90 days in a calendar year receiving an oral evaluation and sealants, and follow-up care after an evaluation. |  |  |
| **Subd. 2** Requires the commissioner to establish a baseline measurement using calendar year 2014 as the base year. |  |  |
| **Subd. 3** requires the commissioner to calculate the measures described under subdivision 1 using fiscal year 2016 and compare these measures with the baseline measures calculated under subdivision 2 and submit the results to the legislature.  If each measure has not increased by at least 20 percent, the dental competitive bidding system shall be implemented by the commissioner if the legislature ratifies its implementation after receipt of the calculations. |  |  |
| **Subd. 4** requires the commissioner to contract through a competitive bidding process to an entity or entities to directly administer the delivery of dental services to all state public health care program enrollees effective for dental service provided on or after January 1, 2019. |  |  |
| **Section 40 (256B.75)** specifies that beginning July 1, 2015, payments to critical access hospitals for outpatient, emergency, and ambulatory surgery hospital facility fee services will be final payments and will not be settled to actual costs. | Identical, except for placement of language. | Article 1, § 24. Hospital outpatient reimbursement. Amends §256B.75. Effective July 1, 2015, provides that rates for outpatient, emergency, and ambulatory surgery hospital facility fee services for critical access hospitals for the payment year are the final payment and not settled to actual costs. |
|  | House only provision | Article 1, § 25. Physician reimbursement. Amends § 256B.76, subd. 1. Effective July 1, 2015, increases payment rates by 90 percent for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase. |
| **Section 41 (256B.76, subd. 2)** increases payment rates for dental services provided on or after July 1, 2015, to the percentage of 2012 fee-for-service submitted charge that results in a 24 percent increase in the aggregate payment from the rates in effect on June 30, 2015.  This increase shall be reflected in the payment rates for managed care plans and county-based purchasing plans effective January 1, 2016. | House increases dental rates by 5 percent over the rate in effect June 30, 2015.  Senate increases dental rates by 24 percent over the rate in effect June 30, 2015, and bases the increase using 2012 submitted charges. | Article 1, § 26. Dental reimbursement. Amend § 256B.76, subd. 2. Effective July 1, 2015, increases payments rates for dental services by 5 percent. Excludes specified providers from the rate increase and requires managed care and county-based purchasing plan payments to be increased to reflect this increase, effective January 1, 2016. |
| **Section 42 (256B.76 subd. 4)** modifies the critical access dental program requiring the commissioner to administer an incentive program that makes payments to dental clinics that meet the following criteria:   1. nonspecialty dental clinics that meet or exceed the annual median ratio of restorative to preventive dental services calculated based on the median ratio of all nonspecialty dental clinics serving public health care program enrollees; and 2. specialty dental clinics that provide services to a fee-for-service or managed care enrollee during the prior year and met or exceeded the annual median for dental providers for that dental specialty serving public health care program enrollees.   Eighty percent of the total payments for this program shall be paid out to nonspecialty dental clinics and 20 percent to specialty dental clinics. The payments made in fiscal year 2016 shall not exceed the total amount paid under the critical access dental program in fiscal year 2015.  For fiscal year 2017 and each fiscal year thereafter, the total payments shall be adjusted annually based on the value of the dental services component of the medical services expenditure category of the CPI-U.  Payments shall be made no later than April 1 of the year following the fiscal year for which payments are owed. | Senate only provision |  |
| **Section 43 (256B.76, subd. 7)** provides for a payment rate increase of one percent for primary care services billed by certain physicians, advanced registered nurse practitioners, and physician assistants, effective July 1, 2015, and an additional 0.25 percent effective November 1, 2017.  Requires payments to managed care plans and county-based purchasing plans to reflect this increase effective, respectively, January 1, 2016, and January 1, 2018. | Senate only provision |  |
|  | House only provision | Article 1, § 27. Reimbursement for health care services. Amends § 256B.762. Effective for services provided on or after July 1, 2015, increases payment for managed care and fee-for-service visits for physical therapy, occupational therapy, and speech therapy by 10 percent, when these services are provided as home health services. Requires the commissioner to adjust managed care and county-based purchasing capitation rates to reflect these payment rates. |
|  | House only provision | Article 1, § 28. Reimbursement for basic care services. Amends § 256B.766. Paragraph (g), effective July 1, 2015, increases payment rates by 90 percent for outpatient hospital facility fees, medical supplies and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, and laboratory services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4). Provides that payments to managed care and county-based purchasing plans shall not be adjusted to reflect this payment increase.  Paragraph (i), effective July 1, 2015, restores payment rates for durable medical equipment, prosthetics, orthotics, or supplies, including individually priced items, to the January 1, 2008 fee schedule rate, updated to include subsequent rate increases. Exempts certain items from this provision. Also requires that a July 1, 2015 3 percent payment increase in current law be calculated using the 2008 fee schedule rate. |
| **Section 44 (256B.767)** specifies that the payment rates for durable medical equipment, prosthetics, orthotics, or supplies on or after July 1, 2015, are not limited to the rates established under Medicare’s competitive bidding program. | Senate provides that for medical equipment, prosthetics, orthotics, and supplies, the rates are not limited by Medicare’s competitive bidding rate; House exempts these items from the requirement that MA payments not exceed the Medicare payment rate.  House adds paragraph (e) which exempts physical therapy, occupational therapy, speech pathology, and related services, and basic care services provided by Gillette Hospital from this section limiting the medical assistance rate to the Medicare rate; Senate does not. | Article 1, § 29. Medicare payment limit. Amends § 256B.767. Paragraph (d), effective July 1, 2015, exempts durable medical equipment, prosthetics, orthotics, or supplies from the requirement that MA payments not exceed the Medicare payment rate.  Paragraph (e), exempts physical therapy, occupational therapy, speech pathology and related services, and basic care services provided by a hospital that specializes in the treatment of cerebral palsy and other conditions, as specified in section 62Q.19, subdivision 1, clause (4), from the requirement that MA payment rates not exceed the Medicare payment rate for the applicable service. |
| **Section 45 (256B.79)** establishes integrated care for high-risk pregnant women. | Senate only provision |  |
| **Subd. 1** defines terms. |  |  |
| **Subd. 2** requires the commissioner to implement a pilot program to improve birth outcomes and strengthen early parental resilience for pregnant women who are receiving MA, are at a significantly elevated risk for adverse outcomes of pregnancy, and are in targeted populations. |  |  |
| **Subd. 3** requires the commissioner to award grants to qualifying applicants to support interdisciplinary, integrated perinatal care. Requires the grants to be distributed through a request for proposals (RFP) process to a designated lead agency within an entity that has been determined to be a qualified integrated perinatal care collaborative or an entity in the process of meeting the qualifications to become a collaborative. |  |  |
| **Subd. 4** specifies that to be eligible for a grant, an entity must show that the entity meets or is in the process of meeting the qualifications established by the commissioner to be a qualified perinatal care collaborative.  Specifies the policies, services, and partnerships that an entity must have in place to meet the qualifications to be a collaborative. |  |  |
| **Subd. 5** requires a collaborative receiving a grant to develop means to identify and report gaps in the  communication, administrative support, and direct care that must be remedied for the collaborative to provide integrated care and enhanced services to targeted populations. |  |  |
| **Subd. 6** requires the commissioner to report to the legislature on the status and progress of the pilot program by January 31, 2019. |  |  |
| **Subd. 7** specifies that this section expires June 30, 2019. |  |  |
| **Section 46 (256L.01, subd.3a)** defines family in the MinnesotaCare program to comply with federal requirements for the basic health plan (BHP). | Identical | Article 2, § 3. Family. Amends § 256L.01, subd. 3a. Defines “family” for purposes of the MinnesotaCare program, for individuals who do not expect to file a federal tax return and do not expect to be claimed as a dependent, and for married couples. Provides an immediate effective date. |
| **Section 47 (256L.01, subd. 5)** clarifies the definition of income to mean a household’s projected annual income for the applicable year. | Identical | Article 2, § 4. Income. Amends § 256L.01, subd. 5. Clarifies that the definition of “income” means a household’s projected annual income for the applicable tax year. Provides an immediate effective date. |
| **Section 48 (256L.03, subd. 5)** updates the family deductible cost-sharing requirement by specifying that the family deductible is equal to $2.75 per month per family, and that it will be annually adjusted by the increase in the medical care component of the CPI-U. Also specifies that cost-sharing requirements do not apply to American Indians. | Identical | Article 2, § 5. Cost-sharing. Amends § 256L.03, subd. 5. The amendment to paragraph (a) specifies that the family deductible for MinnesotaCare is $2.75 per month per family and is adjusted annually by the change in the medical component of the CPI-U.  The amendment to paragraph (b) provides that American Indians are not subject to MinnesotaCare cost-sharing.  States that the amendment related to the family deductible is effective retroactively from January 1, 2014, and the cost-sharing exemption for American Indians is effective the day following final enactment. |
| **Section 49 (256L.04, subd. 1a)** specifies that a Social Security number is required when applying for MinnesotaCare if required under federal regulations. | Senate only provision |  |
| **Section 50 (256L.04, subd. 1c)** clarifies eligibility requirements for MinnesotaCare. | Identical | Article 2, § 6. General requirements. Amends § 256L.04, subd. 1c. Strikes a reference to being eligible for “coverage” under MinnesotaCare. Provides an immediate effective date. |
| **Section 51 (256L.04, subd. 7b)** requires the commissioner to adjust the income limits annually on January 1 as provided in federal regulations. | Identical | Article 2, § 7. Annual income limits adjustment. Amends § 256L.04, subd. 7b. Requires MinnesotaCare program income limits based on the federal poverty guidelines to be adjusted on annually on January 1, as provided in federal regulations. (Under current law, the adjustment is made on July 1.) Provides an immediate effective date. |
|  | House only provision | Article 2, § 8. Citizenship requirements. Amends § 256L.04, subd. 10. Changes the federal citation for a reference to noncitizens who are “lawfully present.” |
| **Section 52 (256L.05, subd. 2a)** specifies that the commissioner must determine eligibility for each applicable period of eligibility, and if the individual is required to pay a premium, that coverage is only available in each month for which a premium has been paid. | Identical | Article 2, § 9.Eligibility and coverage. Amends § 256L.05, by adding subd. 2a. States that an individual is eligible for MinnesotaCare following a determination by the commissioner that the individual meets the eligibility criteria for the applicable period of eligibility. Also states that for individuals required to pay a premium, coverage is only available for months for which a premium is paid. Provides an immediate effective date. |
| **Section 53 (256L.05, subd. 3)** clarifies that coverage for American Indians begins the first day of the month following the month in which eligibility is approved. | Identical | Article 2, § 10. Effective date of coverage. Amends § 256L.05, subd. 3. In a provision specifying the effective date of coverage for persons exempt from premiums, strikes a reference to the month in which verification of American Indian status is received. |
| **Section 54 (256L.05, subd. 3a**) clarifies that eligibility must be redetermined on an annual basis and that the period of eligibility is the entire calendar year following the year in which eligibility is redetermined.  Specifies that beginning in calendar year 2015, eligibility redeterminations shall occur during open enrollment periods for qualified health plans. | Identical | Article 2, § 11. Redetermination of eligibility. Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed on an annual basis, rather than every 12 months. Beginning in CY 2015, requires eligibility redeterminations to occur during the open enrollment period for qualified health plans. Makes related changes. Provides an immediate effective date. |
| **Section 55 (256L.05, subd. 4)** requires the commissioner to determine an applicant’s eligibility for MinnesotaCare no more than 45 days from the date the application was received by the department. | Identical | Article 2, § 12. Application processing. Amends § 256L.05, subd. 4. Increases from 30 to 45 days the time period within which the commissioner must determine an applicant’s eligibility for MinnesotaCare. Provides an immediate effective date. |
| **Section 56 (256L.06, subd. 3)** specifies that disenrollment for nonpayment of the premium is effective for the calendar month following the months the premium was due, and if disenrolled, an individual may not reenroll prior to the first day of the month following payment of an amount equal to two months’ premiums. | Identical | Article 2, § 13. Commissioner’s duties and payment. Amends § 256L.06, subd. 3. Provides that MinnesotaCare disenrollment for nonpayment of premium is effective the month following the month for which the premium was due (under current law, disenrollment is effective the month the premium is due). Allows reenrollment the first day of the month following payment of an amount equal to two months’ premiums, and strikes language requiring retroactive enrollment if certain conditions are met. Provides an immediate effective date. |
| **Section 57 (256L.11, subd. 7a)** specifies that the payment rate for dental services provided on or after January 1, 2016, shall be the rate in effect on December 31, 2015. | Senate only provision |  |
| **Section 58** **(256L.121, subd. 1)** clarifies a cross-reference. | Identical | Article 2, § 14. Competitive process. Amends § 256L.121, subd. 1. Corrects a cross-reference. |
| **Section 59 (256L.15, subd. 2)** modifies the MinnesotaCare premiums to comply with federal regulations.  Specifies that individuals with household incomes below 35 percent of federal poverty guidelines are not required to pay premiums. | Senate only provision |  |
|  | House only provision | Article 2, § 15. Debt. Amends § 270A.03, subd. 5. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date. |
|  | House only provision | Article 2, § 16. Disclosure to commissioner of human services. Amends § 270B.14, subd. 1. Makes a conforming change related to the repeal of MinnesotaCare. Provides a January 1, 2016, effective date. |
| **Section 60 (297A.70, subd. 7)** makes a conforming change to a cross-reference. | Senate only provision |  |
| **Section 61 (Laws 2008, chapter 363, article 18, section 3, subd. 5)** strikes the current limits on aggregate administrative costs paid to managed care plans and county-based purchasing plans. | Identical | Article 1, § 30. Basic health care grants. Amends Laws 2008, ch. 363, art. 18, § 3, subd. 5. Strikes the administrative cost limit that is in an ongoing rider. (The stricken language is reinstated in modified form in § 256B.69, subd. 5i.) |
| **Section 62 (Laws 2014, chapter 312, article 45, subdivision 2)** modifies the expiration date of variances from the operating standards for special transportation service issued by the Commissioner of Human Services to new nonemergency medical transportation providers. | Senate only provision |  |
| **Section 63** **(Advisory Group on Administrative Efficiency and Regulatory Simplification)** requires the Commissioner of Health to convene an advisory group on maximizing administrative efficiency and regulatory simplification in state public health care programs. | Senate only provision | See House Article 1, section 32 |
| **Section 64** (**Statewide Opioid Prescribing Improvement Program)** requires the Commissioner of Human Services to report to the legislature by December 1, 2015, any recommendations made by the opioid prescribing work group and steps taken to implement the opioid prescribing improvement program. | Senate only provision |  |
| **Section 65 (Task Force on Health Care Financing)** requires the Governor to convene a task force on health care financing to advise the Governor and legislature on strategies that will increase access to and improve the quality of health care for Minnesotans. | Senate only provision |  |
| **Section 66 (Health Disparities Payment Enhancement)** requires the Commissioner of Human Services to develop a methodology to pay a higher payment rate for providers and services that takes into account the higher cost, complexity, and resources needed to serve patients and populations who experience the greatest health disparities.  The commissioner must submit a report to the legislature by December 15, 2015, that includes recommendations and a proposed methodology for providing a health disparities payment adjustment. | Senate only provision |  |
|  | House only provision | Article 1, § 31. Reduction in administrative costs. Requires the commissioner of human services to negotiate reductions in managed care and county-based purchasing administrative costs, sufficient to achieve state MA savings of $100,000,000 for the biennium ending June 30, 2017. |
| See Senate section 63 | House only provision | Article 1, § 32. Advisory group on administrative expenses. Directs the commissioner of health to reconvene the Advisory Group on Administrative Expenses, to develop standards and procedures for examining state public program administrative expenses. Specifies related duties and membership. |
|  | House only provision | Article 1, § 33. Capitation payment delay. (a) Requires the commissioner of human services to delay $135 million in MA capitation payments due in May 2017, and special needs basic care payments due in April 2017, until July 1, 2017. Requires the payment to be made between July 1 and July 31, 2017.  (b) Requires the commissioner of human services to delay $135 million in MA capitation payments due in the second quarter of CY 2019 and the April 2019 payment for special needs basic care, until July 1, 2019. Requires the payment to be made between July 1 and July 31, 2019. |
|  | House only provision | Article 1, § 34. Health and economic assistance program eligibility verification audit services.  Subd. 1. Request for proposals. Requires the commissioner of human services, by October 1, 2015, to issue a request for proposals for a contract to provide eligibility verification audit services for health and economic assistance program benefits. Provides that the RFP must require the vendor to:  (1) conduct an eligibility verification audit of all health and economic assistance program recipients that includes, but is not limited to, data matching against relevant state and federal data bases;  (2) identify any ineligible recipients in these programs and report these findings to the commissioner; and  (3) identify a process for ongoing eligibility verification of health and economic assistance program applicants and recipients.  Subd. 2. Additional vendor criteria. Provides that the RFP must require the following minimum vendor capabilities and experience: a rules-based process for making eligibility determinations, eligibility advocates to assist recipients through the verification process, a formal claims and appeals process, and experience in performing eligibility verification audits.  Subd. 3. Contract required. Requires the commissioner to enter into a contract with a vendor by January 1, 2016. Requires the contract to: (1) incorporate performance-based vendor financing that compensates the vendor based on the amount of savings generated; (2) require the vendor to reimburse the commissioner and county agencies for reasonable costs incurred in implementing this section; (3) require the vendor to comply with enrollee data privacy requirements and use encryption; and (4) provide penalties for vendor noncompliance. States that the contract may be renewed for three additional one-year periods, and allows the commissioner to require additional audits if specified conditions are met.  Subd. 4. Health and economic assistance program. Defines health and economic assistance program as the MA program, MFIP and diversionary work programs, child care assistance programs, general assistance, alternative care, and chemical dependency programs. |
|  | House only provision | Article 1, § 35. Request for proposals. Requires the commissioner of human services to issue a request for proposals to use technologically advanced software and services to improve the identification and rejection or elimination of improper Medicaid payments and improper provision of benefits by a health and economic assistance program. Specifies criteria for the RFP. Requires the commissioner, based upon responses, to enter into a contract by October 1, 2015. Requires the contract to incorporate a performance-based vendor financing option. Provides an immediate effective date. |
|  | House only provision | Article 1, § 36. Federal waiver or approval. Requires the commissioner of human services to seek any federal waiver or approval necessary to implement the amendment to section 256B.0644 (exemption of certain dentists from the state health care program participation requirement). |
|  | House only provision | Article 2, § 17. Revisor instruction. Directs the revisor to strike references to MinnesotaCare and make grammatical and conforming changes, in Minnesota Statutes and Minnesota Rules. |
| **Section 67 (Repealer)** repeals the following:  (a) Minnesota Statutes, sections 256.969, subd. 30 (payment for births); and 256B.69, subd. 32 (initiatives to reduce incidence of low birth weight), effective July 1, 2015.  (b) Minnesota Statutes, sections 256L.02, subd. 3 (financial management for MinnesotaCare); and 256L.05, subd. 1b (MinnesotaCare enrollment by counties), 1c (open enrollment and streamlined application), 3c (retroactive coverage), and 5 (availability of private insurance), effective the day following final enactment.  (c) Minnesota Statutes, section 256L.11, subd. 7 (MinnesotaCare critical access dental payments), effective July 1, 2015.  (d) Repeals rules requiring providers of special transportation services to conduct driver and criminal record checks. | House repeals the MinnesotaCare program and related sections effective January 1, 2016. House does not include any of the Senate repealers. | Article 2, § 18. Repealer.  Subd. 1. MinnesotaCare program. Repeals all sections of Minnesota Statutes, chapter 256L (the MinnesotaCare program).  Subd. 2. Conforming repealers. Repeals sections 13.461, subd. 26, 16A.724, subdivision 3, 62A.046, subd. 5, and 256.01, subd. 35, to conform to the repeal of the MinnesotaCare program.  Provides a January 1, 2016, effective date. |