Bill Summary Comparison of

Health and Human Services

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| Senate File 1458 | Senate File 1458, 1st Unofficial Engrossment |
| Article 8, Health Care Delivery | Articles 1 & 6, Health Care; Public Health; and Health Care Delivery |

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| Article 8: Health Care Delivery |  | Articles 1 & 6: Health Care; Public Health; Health Care Delivery |
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| **Section 1 (62A.67)** permits these sections to be cited as the “Minnesota Telemedicine Act.” | Identical, except for effective date;  Senate: 1/1/16 House: 1/1/17 | Section 1 (Article 6). Short title. Adds § 62A.67. States that sections 62A.67 to 62A.672 may be cited as the “Minnesota Telemedicine Act.”  Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date. |
| **Section 2 (62A.671)** defines the following terms:  distant site; health care provider; health carrier; health plan; licensed health care provider; originating site; store-and-forward technology; and telemedicine. | Identical, except for effective date;  Senate: 1/1/16 House: 1/1/17 | Section 2 (Article 6). Definitions. Adds § 62A.671. Defines terms for the Minnesota Telemedicine Act.  Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date. |
| **Section 3 (62A.672)** requires the coverage of telemedicine services. | Similar, differences in subd. 3 and Senate adds a subd.4 | Section 3 (Article 6). Coverage for telemedicine services. Adds § 62A.672.  Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date. |
| **Subdivision 1** requires a health plan issued or renewed on or after January 1, 2017, to cover telemedicine benefits in the same manner as any other benefit covered under the health plan. | Identical | Subd. 1. Coverage of telemedicine. (a) Requires health plans to cover telemedicine benefits in the same manner as any other benefits covered under the plan.  (b) States that this section shall not be construed to (1) requires a health carrier to provide coverage for services that are not medically necessary; (2) prohibit a health carrier from establishing criteria that a health care provider must meet for the delivery of telemedicine, so long as the criteria is not unduly burdensome or unreasonable; or (3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices, so long as they are not unduly burdensome or unreasonable. |
| **Subdivision 2** prohibits a health carrier from denying coverage of a service solely because the service was delivered via telemedicine and was not provided through in-person contact between the licensed health care provider and patient. | Identical | Subd. 2. Parity between telemedicine and in-person services. Prohibits a health carrier from excluding a service for coverage solely because the service is provided via telemedicine and not provided through in-person consultation or contact. |
| **Subdivision 3** requires the health carrier to reimburse the distant site provider for services delivered via telemedicine on the same basis and at the same rate as would apply to the services, consultation, or contacts if provided in person.  Permits the health carrier to require a deductible, co-payment, or coinsurance for services provided by telemedicine so long as the deductible, co-payment, or coinsurance does not exceed the deductible, co-payment, or coinsurance applicable if the service is provided through in-person contact. | Senate paragraph (a) reimburses “on the same basis and at the same rate as the health carrier” would apply to an in person visit.  House paragraph (a) reimburses “commensurate with the costs of delivering health care services though telemedicine” and has the distant site provider as the responsible party for reimbursing fees to the originating site. | Subd. 3. Reimbursement for telemedicine services. (a) Requires a health carrier to reimburse a distant site provider for covered services delivered via telemedicine commensurate with the cost of delivering health care services through telemedicine. States that the distant site provider is responsible for reimbursing any fees to the originating site.  (b) States that it is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, so long as it is not in addition to and does not exceed any payment that would applicable for in-person contact. |
| **Subdivision 4** requires a health carrier to make a facility fee payment to the originating site health care provider for the delivery of telemedicine to the enrollee.  The facility fee payment to the originating site provider is in addition to the reimbursement to the distant site provider.  This payment is not subject to any patient coinsurance, deductible, or co-payment obligation. | Senate only provision |  |
| **Section 4 (62J.497, subd. 1)** adds a definition of utilization review organization. | Senate only provision |  |
| **Section 5 (62J.497, subd. 3)** requires group purchasers and utilization review organizations to develop processes to ensure notifications to prescribers upon a denial of a claim for a prescribed drug that is not covered or is not included in the group purchaser’s formulary.  Requires the process to provide a list of covered drugs from the same class or classes as the drug originally prescribed. | Senate only provision |  |
| **Section 6 (62J.497, subd. 4)** requires providers, group purchasers, prescribers, dispensers, and utilization review organizations that use paper forms for prescription drugs prior authorization, or for medical exception requests, to only use the uniform formulary exception form. | Senate only provision |  |
| **Section 7 (62J.497, subd. 5)** requires testing of electronic drug prior authorization transmission to begin no later than October 1, 2015. | Senate only provision |  |
| **Section 8 (62M.01, subd. 2)** clarifies that chapter 62M does not apply to the medical assistance fee-for-service program unless otherwise required. | Senate only provision |  |
| **Section 9 (62M.02, subd. 10a)** adds a definition for “drug.” | Senate only provision |  |
| **Section 10 (62M.02, subd. 11a)** adds a definition for “formulary.” | Senate only provision |  |
| **Section 11 (62M.02, subd. 12)** modifies the definition of health benefit plan to include a health plan that provides coverage of prescription drugs. | Senate only provision |  |
| **Section 12 (62M.02, subd. 14)** modifies the definition of “outpatient services” to include prescription drugs. | Senate only provision |  |
| **Section 13 (62M.02, subd. 14b)** adds a definition for “prescription.” | Senate only provision |  |
| **Section 14 (62M.02, subd. 14c)** adds a definition for “prescription drug order.” | Senate only provision |  |
| **Section 15 (62M.02, subd. 15)** modifies the definition of  “prior authorization” to include preadmission review, pretreatment review, pharmaceutical utilization management procedures, utilization, and case management and any utilization review organization’s requirement that an enrollee or provider notify the utilization review organization prior to providing a service. | Senate only provision |  |
| **Section 16 (62M.01, subd. 17)** modifies the definition of “provider” to include a licensed pharmacist. | Senate only provision |  |
| **Section 17 (62M.01, subd. 18a)** adds a definition for “quantity limit.” | Senate only provision |  |
| **Section 18 (62M.01, subd. 19a)** adds a definition for “step therapy.” | Senate only provision |  |
| **Section 19 (62M.05, subd. 3a)** modifies the time in which an initial determination on requests for utilization review must be communicated to the provider and enrollee from ten business days to five business days of the request. | Senate only provision |  |
| **Section 20 (62M.05, subd. 3b)** modifies the time in which notification of an expedited initial determination to either certify or not to certify must be provided to the provider and enrollee from no later than 72 hours to no later than 36 hours from the initial request. | Senate only provision |  |
| **Section 21 (62M.05, subd. 4)** requires a utilization review organization to have written procedures to address processes by which the utilization review organization must track and manage review requests and documentation submitted by providers and enrollees.  Specifies that if a utilization review organization fails to meet specified timelines, or fails to notify a provider that information needed to conduct the review is incomplete, or fails to properly maintain submitted records for which the provider or enrollee has documentation of submission, the service will be deemed approved. | Senate only provision |  |
| **Section 22 (62M.06, subd. 2)** modifies the time in which a utilization review organization must notify the enrollee and attending health care professional of its determination on the expedited appeal from no later than 72 hours to no later than 36 hours after receiving the expedited appeal. | Senate only provision |  |
| **Section 23 (62M.06, subd. 3)** modifies the time in which a utilization review organization must notify the enrollee, attending health care professional, and claims administrator of its determination on a standard appeal from 30 days to 15 days upon receipt of the notice to appeal.  If the utilization review organization cannot make a determination within 15 days due to circumstances outside the control of the review organization, the review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administrator of its determination.  If it takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator in advance of the extension and reasons for it. | Senate only provision |  |
| **Section 24 (62M.07), Paragraph (d)**, specifies that any authorization for a prescription drug must remain valid for the duration of an enrollee’s benefit year or enrollment year so long as the drug continues to be prescribed to the patient, the drug remains safe, has not been withdrawn from use by the FDA or the manufacturer, no evidence of an enrollee’s abuse or misuse of the medication, and no drug warnings or recommended changes in drug usage has occurred.  **Paragraph (e)** prohibits a utilization review organization, health Plan Company, or claims administrator from imposing step therapy requirements for enrollees currently on a prescription drug for six specified classes. | Senate only provision |  |
| **Section 25 (62M.09, subd. 3)** requires all physicians conducting the review in connection with any policy issued by a health plan company, regardless of size to be licensed in Minnesota. | Senate only provision |  |
| **Section 26 (62M.10, subd. 7)** requires a utilization review organization to provide upon request to an enrollee, provider, and the commissioner of commerce, the written clinical criteria used to determine medical necessity, appropriateness, and efficacy of a procedure or service. Permits this requirement to be met by posting the written clinical criteria on the utilization review organization’s public Web site or by electronic distribution to the enrollee or provider. | Senate only provision |  |
| **Section 27 (62M.11)** permits a provider to file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization. | Senate only provision |  |
| **Section 28 (62M.17)** requires utilization review organizations to annually report to the Commissioner of Health specified information regarding medical exception requests and for other prescription drug prior authorization requests. | Senate only provision |  |
| **Section 29 (62Q.02)** clarifies that chapter 62Q does not apply to public health care programs administered by the commissioner of human services unless otherwise required by law or regulation. | Senate only provision |  |
| **Section 30 (62Q.83)** permits enrollees of a health plan company (HPC) or pharmacy benefit manager to choose where they obtain their pharmacy services. | Senate only provision |  |
| **Subd. 1** prohibits a HPC or PBM from limiting or restricting an enrollee’s ability to select a pharmacy or pharmacist of the enrollee’s choice if the pharmacy or pharmacist is licensed in the state and the pharmacy or pharmacist has agreed to the terms of the HPC or PBM provider contract.  Specifies that this subdivision does not apply to an enrollee in the Minnesota restricted recipient program. | Senate only provision |  |
| **Subd. 2** prohibits a HPC or PBM from denying a pharmacy or pharmacist the right to participate in its pharmacy network contracts if the pharmacy or pharmacist has a valid license in their state and agrees to accept the terms and conditions  offered by the HPC or PBM and meets all state and federal laws and regulations. | Senate only provision |  |
| **Subd. 3** prohibits a HPC or PBM from imposing a cost-sharing requirement or other fee on an enrollee for selecting a pharmacy or pharmacist or impose conditions that limit or restrict an enrollee’s choice unless the same cost-sharing, fees, limits, or conditions are imposed on an enrollee’s selection of any pharmacy within the provider network contracts. | Senate only provision |  |
| **Subd. 4** defines pharmacy and pharmacy benefit manager. | Senate only provision |  |
| **Section 31 (62Q.84)** requires a HPC or PBM to provide payment for any health care service that is a covered benefit and provided by a licensed pharmacist if the service performed is within the scope of practice of the licensed pharmacist and the service would be covered if the service was performed by a physician, advanced practice registered nurse or physician assistant. | Senate only provision |  |
| **Section 32 (62Q.85)** creates prescription drug benefit transparency and management requirements. | Senate only provision |  |
| **Subd. 1** defines the following terms:  drug; formulary; health plan company; and prescription. | Senate only provision |  |
| **Subd. 2** requires a health plan company that cover prescription drugs and uses a formulary to make its formulary and related benefit information available by electronic means and, upon request, in writing at least 30 days prior to annual renewal dates. | Senate only provision |  |
| **Subd. 3. Paragraph (a),** specifies that once a formulary has been established a health plan company, may at any time during an enrollee’s contract year, expand its formulary by adding drugs to the formulary; reduce the copayments or coinsurance; or move a drug to a benefit category that reduces the enrollee’s cost.  **Paragraph (b)** states that a health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee’s cost only if an A-rated generic or multisource brand name equivalent is added to the formulary at a lower cost to the enrollee and upon 60 notice to prescribers, pharmacists, and affected enrollees.  **Paragraph (c)** prohibits a health plan company from removing drugs from its formulary or moving drugs to a benefit category that increases an enrollee’s cost during the enrollee’s contract year.  This prohibition does not apply if the change is associated with the drug being deemed unsafe by the FDA or it has been withdrawn by the FDA or the manufacturer, or an independent source has issued drug specific warnings or recommended changes in drug usage.  **Paragraph (d)** prohibits managed care plans and county-based purchasing plans from removing drugs from its formulary or moving a drug to a benefit category that increases an enrollee’s cost more than annually unless an A-rated generic or multisource brand name equivalent is added to formulary. | Senate only provision |  |
| **Subd. 4. Paragraph (a)** requires a health plan company to establish and maintain a transition process to prevent gaps in prescription drug coverage for enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.  **Paragraph (b)** requires the process to provide coverage for at least 60 days.  **Paragraph (c)** requires that any cost-sharing applied be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that would be charged for no formulary drugs approved under a medication exceptions process.  **Paragraph (d)** requires the health plan company to ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage. | Senate only provision |  |
| **Subd. 5. Paragraph (a)** requires each health plan company to establish and maintain a medical exceptions process that allows enrollees, providers, and an authorized representative to request and obtain coverage approval in certain situations.  **Paragraph (b)** requires the exception to remain valid for the duration of an enrollee’s contract term provided that the medication continues to be prescribed of the same condition, and the medication has not been withdrawn by the manufacturer or the FDA.  **Paragraph (c)** requires the medical exceptions process to comply with the requirements under chapter 62M (utilization review). | Senate only provision |  |
| **Subd. 6** requires the Commissioner of Health to convene an advisory group to provide guidance in monitoring changes and trends in prescription drug coverage and formulary design.  Requires the commissioner to submit a report to the legislature on a biennial basis beginning January 15, 2017, describing trends in prescription drug coverage, formulary design, medication exception requests, and benefit designs.  Requires health plan companies to cooperate in providing information necessary for the advisory group to carry out its responsibilities. | Senate only provision |  |
| **Section 33 (62U.02, subd. 1)** requires the commissioner to stratify five quality measures the Commissioner of Health is required to develop to assess the quality of health care services offered by health care providers that are to be used for the quality incentive payment system by race, ethnicity, preferred language, and country of origin effective July 1, 2016. Permits the commissioner to require that other socio-demographics that are correlated with health disparities and have an impact on performance, quality, and cost indicators be considered after voluntary pilot projects are completed.  Requires the commissioner to consult with the communities impacted by health disparities through culturally appropriate community engagement principles and methods.  Specifies that the commissioner does not have the authority to collect or analyze patient-level or patient-specific data of the patient's characteristics. | Senate only provision |  |
| **Section 34 (62U.02, subd. 2)** requires that the quality incentive payment system developed by the commissioner under this section adjust for variations in patient population to reduce incentives for providers to avoid patients with risk factors related to race, ethnicity, language, country of origin, and socio-demographic factors. | Senate only provision |  |
| **Section 35 (62U.02, subd. 3)** requires that the risk adjustment system that the commissioner is developing under this section take into account patient characteristics that are correlated with health disparities and have an impact on performance, cost, and quality measures. Permits the risk adjustment method to be based on reporting based on an actual to expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. | Senate only provision |  |
| **Section 36 (62U.02, subd. 4)** specifies that if the commissioner contracts with a private entity to complete the requirements of this section that the entity has a governance that includes representatives of providers serving high concentration of patients and communities impacted by health disparities, and consumers who represent groups who experience health disparities. | Senate only provision |  |
| **Section 37 (144E.001, subd. 5h)** adds a definition of community medical response emergency medical technician (CEMT) to the Emergency Medical Services Regulatory Board chapter of law. | Identical | Section 11 (Article 6). Community medical response emergency medical technician. Amends § 144E.001 by adding subdivision 5h. Defines “community medical response emergency medical technician” or “CEMT.” |
| **Section 38 (144E.275, subd.  1)** expands the definition of medical response unit to permit medical response units to provide CEMT services. | Senate references subdivision 7 for a medical response unit’s use of a CEMT (next section).  House allows medical response units to, subject to requirements, provide episodic population health support, episodic individual patient education, and prevention education programs (does not reference CEMT). | Section 12 (Article 6). Definition. Amends § 144E.275, subdivision 1. Allows a medical response unit to provide, under certain conditions, episodic population health support, episodic individual patient education, and prevention education programs. |
| **Section 39 (144E.275, subd.  7)** specifies the prerequisites for an individual to be certified by the board as a CEMT; requires a CEMT to practice under the supervision of the medical director of the CEMT’s medical response unit; specifies the services a CEMT is permitted to provide; clarifies that CEMTs are not exempt from any of the regulatory requirements for EMTs or AEMTs; and further limits CEMT services by prohibiting most home care services. | Senate language in paragraph (a) requires CEMTs to receive training in providing culturally appropriate care and in paragraph (c) requires all CEMT-provided services to be within the CEMT skill set.  Technical difference in paragraphs (d) and (f). Staff recommends Senate | Section 13. Community medical response emergency medical technician. Amends § 144E.275 by adding subdivision 7. (a) States eligibility to be certified as a CEMT, including, but not limited to, current certification as an EMT or AEMT, two years of service as an EMT or AEMT, and successful completion of a CEMT training program.  (b) Requires a CEMT to practice in accordance with standards established by the medical response unit medical director.  (c) Allows a CEMT to provide services approved by the medical response unit medical director.  (d) Limits when a CEMT may provide episodic individual patient education and prevention education and states limitations.  (e) Subjects a CEMT to the same certification, disciplinary, complaint, and other regulations as applied to EMTs.  (f) Prohibits a CEMT from providing services defined in section 144A.471, subdivision 6 and 7 (basic and comprehensive home care) with limited exceptions. |
| **Section 40 (151.58, subd. 2)** modifies the definition of a health care facility for purposes of the use of automated drug distribution systems to include a boarding care home that provides centralized storage of medications. | Identical | Section 3 (Article 1). Definitions. Amends § 151.58, subd. 2. Includes a boarding care home that provides centralized storage of medications in the definition of “health care facility,” for purposes of the use of automated drug distribution systems. |
| **Section 41 (151.58, subd. 5)** creates an exemption from the requirement that a pharmacist employed by and working at the managing pharmacy certify that accuracy of the filling of the cassettes, canisters, or other containers that contain drugs that are loaded into an automated drug distribution system if the filled cassette, canister, or other container has been provided by a repackage registered by the FDA and licensed by the Board of Pharmacy as a manufacturer. | Identical | Section 4 (Article 1). Operation of automated drug distribution systems. Amends § 151.58, subd. 5. Provides an exemption from the requirement that a pharmacist employed by and working at the managing pharmacy certify the accuracy of the filling of any cassettes, canisters, or containers of drugs that will be loaded into the automated drug distribution system. This requirement would not apply if the filled cassettes, canisters, or containers have been provided by a repackager registered with the FDA, and licensed by the board as a manufacturer. |
| **Section 42 (256B.0625, subdivision 3b)** specifies that medical assistance cover services and consultations delivered via telemedicine as defined under section 62A.71, subdivision 9 (real-time two-way, interactive audio and visual communications and through technologies consisting of telephones, patient monitoring devises or other electronic means) in the same manner as if the service or consultation was delivered in person.  Requires medical assistance to provide a facility fee payment to the originating site provider. Requires the commissioner to make a facility fee payment to the originating site health care provider in an amount equivalent to the originated site fee paid by Medicare.  No fee shall be paid to a health care provider that is being paid under a cost-based methodology or the fee has already been paid by Medicare for a dually eligible enrollee. | Identical, except for House adds paragraph (f) and effective date is different - Senate: 1/1/16 House: 1/1/17. | Section 22 (Article 6). Telemedicine services. Amends § 256B.0625, subdivision 3b. (a) States that medical assistance covers medically necessary services provided via telemedicine in the same manner as in-person.  (b) Requires the commissioner of human services to establish a criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine and states what the attestation may include.  (c) Requires providers to document each occurrence of services provided by telemedicine as a condition of payment and statement documentation requirements.  (d) Requires the commissioner to make a facility fee payment to the originating site equal to the amount of the originating site fee paid by Medicare. Prohibits a facility fee from being paid to a health care provider that is being paid under a cost-based methodology or if Medicare has already paid the facility fee.  (e) Cross-references other sections for definitions.  (f) States that the criteria in paragraph (b) does not apply to managed care organizations and county-based purchasing plans, which may establish criteria for coverage of telemedicine services.  Effective date. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date. |
| **Section 43 (256B.0625, subd. 13)** modifies the reimbursement for over-the-counter medications under medical assistance by specifying that the payment is the lowest of:  (1) the number of dosage units in the manufacturer’s original package; (2) the number of dosage units required to complete the patient’s course of therapy; or (3) if applicable, the number of dosage units dispensed for a system using retrospective billing as permitted under section 256B.0625, subd. 13e, paragraph (b). | Identical | Section 9 (Article 1). Drugs. Amends § 256B.0625, subd. 13. Modifies the procedure used to calculate the number of dosage units of an over-the-counter medication that can be dispensed under MA. Current law requires this quantity to be the lowest of the number of dosage units in the manufacturer’s original package or the number dosage units required to complete the patient’s course of therapy. This section adds to this list the number of dosage units dispensed from a system using retrospective billing. Provides an effective date of January 1, 2016, or upon federal approval, whichever is later. |
| **Section 44** **(256B.0625, subd. 13e, paragraph (a)**) clarifies that the pharmacy dispensing fee for over-the-counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer’s original package.  **Paragraph (b)** authorizes pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system or a packaging system that meet the rules governing the return of unused drugs to the pharmacy for reuse to use retrospective billing for prescription drugs dispensed to long-term care facility residents.  The pharmacy must submit a claim only for the quantity of medication used by the recipient during the defined billing period and the pharmacy must use a billing period not less than one calendar month or 30 days.  **Paragraph (c)** specifies that a pharmacy that is using a packaging system is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse unless the pharmacy is using a retrospective rebilling. | Identical except for technical differences (staff recommends Senate language). | Section 10 (Article 1). Payment rates. Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) specifies the pharmacy dispensing fee for over-the-counter drugs that applies when a retrospectively billing pharmacy bills for quantities less than the number of units in the manufacturer’s original package.  A new paragraph (b) allows pharmacies dispensing prescriptions to residents of long-term care facilities, that use an automated drug distribution system, or a packaging system that meets the standards in rule that allow drugs to be returned, to use retrospective billing. Requires claims to be submitted only for the quantity of medication used during a defined billing period, and requires a retrospectively billing pharmacy to use a billing period not less than one calendar month or 30 days.  The amendment to paragraph (c) exempts pharmacies that use a packaging system that allows drugs to be returned from the requirement to credit DHS for the acquisition cost of all unused drugs, if that pharmacy uses retrospective billing.  Provides an effective date of January 1, 2016, or upon federal approval, whichever is later. |
| **Section 45  (256B.072)** requires that the measures used in the performance reporting system established by the Commissioner of Human Services for health care providers who provide services to public program recipients must be stratified by race, ethnicity, preferred language, and country of origin and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b). | Senate only provision |  |
| **Section 46 (256B.69, subd. 6)** specifies that managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.85, for purposes of delivering services under the prepaid medical assistance program. | Senate only provision |  |
| **Section 47 (Prescription Drug Advisory Council)**sets deadlines for the first appointments and the first meeting of the Prescription Drug Advisory Council. | Senate only provision |  |
| **Section 48 (Proposal for Child Protection Focused CEMT Model)**requires the commissioner to develop a proposal for a pilot program to coordinate services between child protective services and CEMTs. | Senate only provision |  |
| **Section 49 (CEMT Technical Services Covered under Medical Assistance)** requires that by January 15, 2016, the Commissioner of Human Services, in consultation with specified stakeholders, recommend to the legislature which CEMT services are to be covered under medical assistance and what the payment rates for those services are to be. | Senate language restricts eligible services to those within the CEMTs skill set; house lists certain allowable services. | Section 23 (Article 6). Community medical response emergency medical technician services covered under the medical assistance program.  (a) Requires the commissioner of human services, in consultation with other specified persons, to determine services and payment rates for CEMTs to be covered by medical assistance.  (b) Requires payment for services provided by a CEMT to meet certain conditions, including, but not limited to, having been part of a patient care plan and billed by an eligible medical assistance enrolled provider.  (c) Requires the commissioner of human services to submit the list of services to certain members of the legislature by February 15, 2016. States that no services will be covered until legislation providing coverage is enacted. |
| **Section 50** **(Evaluation of CEMT Services)** In the event that legislation is enacted to cover CEMT services, under medical assistance, this section requires the Commissioner of Human Services to provide a report to the legislature on the cost, quality, and coordination of CEMT services. | Technical differences (staff recommends Senate language). | Section 24 (Article 6). Evaluation of Community Advanced Emergency Medical Technician Services. Requires the commissioner of human services, if medical assistance coverage legislation is enacted, to evaluate the effect on medical assistance and MinnesotaCare and reporting findings to certain members of the legislature by December 1, 2017. |
| **Section 51** is a Revisor’s instruction to comply with the changes in chapter 62M. | Senate only provision |  |