Bill Summary Comparison of Health and Human Services

House File 2749,
Unofficial Engrossment (UEH2749-1)
Article 25: Health Care

House File 3467,
Third Engrossment (H3467-3)
Articles 1: Continuing Care, 2: Health Care, and 3: MNsure

Prepared by:
Senate Counsel, Research and Fiscal Analysis and House Research

May 4, 2016

SENATE		HOUSE
Article 25: Health Care		**Articles 1, 2, and 3**
Section 1 (16A.724, subd. 2) increases the amount transferred each biennium from the health care access fund to the general fund to reflect the current value of the medical assistance and MinnesotaCare revenue that is included in the HMO premiums and provider gross revenue taxes to cover the increase in the provider's rates.	Senate only	
	House only	**A3, § 1. Legislative enactment required.** Adds § 45.0131. **Subd. 1. Agency agreements.** Prohibits the commissioner of commerce from entering into or renewing any interagency agreement or service level agreement, or related agreement, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. **Subd. 2. Transfers.** Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. **Subd. 3. Definitions.** Defines "state department" and "state agency." **Effective date.** Provides an immediate effective date.
Section 2 (62J.497, subd. 1) adds a definition of utilization review organization.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 3 (62J.497, subd. 3) requires group purchasers and utilization review organizations other than workers' compensation plans and the medical component of an automobile insurance coverage, to develop processes to ensure that prescribers can obtain information about covered drugs from the same class or classes or a drug originally prescribed that was denied.	Senate only	
Section 4 (62M.02, subd. 10a) adds a definition for "drug."	Senate only	
Section 5 (62M.02, subd. 11a) adds a definition for "formulary."	Senate only	
Section 6 (62M.02, subd. 12) modifies the definition of health benefit plan to include a health plan that provides coverage of prescription drugs.	Senate only	
Section 7 (62M.02, subd. 14) modifies the definition of "outpatient services" to include prescription drugs.	Senate only	
Section 8 (62M.02, subd. 14a) adds a definition for "prescription."	Senate only	
Section 9 (62M.02, subd. 14b) adds a definition for "prescription drug order."	Senate only	
Section 10 (62M.02, subd. 15) modifies the definition of "prior authorization" to include preadmission review, pretreatment review, quantity limits, step therapy, 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	
Section 11 (62M.02, subd. 17) modifies the definition of "provider" to include a licensed pharmacist.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 12 (62M.02, subd. 18a) adds a definition for "quantity limit."	Senate only	
Section 13 (62M.02, subd. 19a) adds a definition for "step therapy."	Senate only	
Section 14 (62M.05, subd. 3a) modifies the time in which an initial determination on requests for utilization review on prescription drug requests must be communicated to the provider and enrollee from ten business days to five business days of the request.	Senate only	
Section 15 (62M.05, subd. 3b) modifies the time in which notification of an expedited initial determination to either certify on prescription drug requests 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	
Section 16 (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 on prescription drug requests from no later than 72 hours to no later than 36 hours after receiving the expedited appeal.	Senate only	
Section 17 (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 on prescription drugs 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,	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
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.		
Section 18 (62M.07), Paragraph (d), specifies that any authorization for a prescription drug must remain valid for the duration of an enrollee's contract term 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, 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. **Paragraph (f)** prohibits a utilization review organization, health plan company, or claims administrator from imposing step therapy requirements on enrollees who are currently taking a prescription drug for which the patient satisfied a previous step therapy requirement.	Senate only	
Section 19 (62M.09, subd. 3) requires all physicians conducting the review in connection with any policy issued by a health plan company, regardless of size, be licensed in Minnesota.	Senate only	

SENATE		HOUSE
Article 25: Health Care		**Articles 1, 2, and 3**
Section 20 (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	
Section 21 (62Q.81, subd. 4) clarifies that autism spectrum disorder treatments specified in section 62A.3094 are rehabilitative and habilitative services for purposes of the essential health benefits. This section is effective upon a formal determination from CMS that these services are not a new state mandate.	Senate only	
Section 22 (62Q.83) creates prescription drug benefit transparency and management requirements. **Subdivision 1** defines the following terms: drug; enrollee contract year; formulary; health plan company; and prescription. **Subdivision 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. **Subdivision 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	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
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)** permits a health plan company to change utilization review requirements or move drugs to a benefit category that increases an enrollee's cost during the enrollee's contract year upon a 60-day notice provided the change does not apply to enrollees who are currently taking the drugs affects by the change for the duration of the enrollee's contract year. **Paragraph (d)** permits a health plan company to remove any drug from its formulary that has been 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. **Subdivision 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		

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
charged for nonformulary 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. **Subdivision 5, paragraph (a)** requires each health plan company to establish and maintain a medication exceptions process that allows enrollees, providers, and an authorized representative to request and obtain coverage approval in certain situations. **Paragraph (b)** requires the exception request 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).		
	House only	**A3, § 2. Application of other law.** Amends § 62V.03, subd. 2. Requires meetings of the Minnesota Eligibility System Executive Steering Committee to comply with the open meeting law.
	House only	**A3, § 3. Appointment.** Amends § 62V.04, subd. 2. Removes the commissioner of human services or a designee from membership on the MNsure board and adds a member representing the interests of the general public.

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
	House only	**A3, § 4. Terms.** Amends § 62V.04, subd. 3. Removes a reference to the term served on the MNsure board by the commissioner of human services or a designee, to conform to section 62V.04, subdivision 2.
	House only	**A3, § 5. Conflicts of interest.** Amends § 62V.04, subd. 4. Modifies a cross-reference to require all board members, including the member representing the interests of the general public, to comply with the conflict of interest requirements for MNsure board members. (Under current law the conflict of interest requirements do not apply to the commissioner of human services.)
Section 23 (62V.041) establishes a shared eligibility system that supports the eligibility determinations that use a modified adjusted gross income methodology for medical assistance, MinnesotaCare, and qualified health plan enrollment. Requires the steering committee of the shared eligibility system to establish an overall governance structure for the system, including setting goals and priorities, allocating resources, and making major system decisions. Requires the steering committee to operate under a consensus model and give particular attention to parts of the system with the largest enrollments and the greatest risks. Requires MN.IT to be responsible for the design, building, maintenance, operation, and upgrade of the information technology for the system.	Numerous differences: • Senate 7 members (2 appointed by the commissioner of human services, 2 by MNsure, 2 by MN.IT, and 1 county representative appointed by the commissioner) and House 4 members (1 appointed by the commissioner, 1 by MNsure, 1 by county associations, and 1 nonvoting member by MN.IT) • Senate requires the commissioner of human services to designate as chair one of the members appointed by the commissioner; House designates the member appointed by MN.IT as chair • House requires steering committee costs to be paid for by DHS, MN.IT, and MNsure • House requires tracking of funding and expenditures and quarterly reports to LOC • Senate has language on operating by consensus, to extent feasible • House specifies criteria for meetings and voting	**A3, § 10. Minnesota Eligibility System Executive Steering Committee.** Adds § 62V.056. Establishes an executive steering committee to govern the Minnesota eligibility system. **Subd. 1. Definition; Minnesota eligibility system.** Defines Minnesota eligibility system as the system that supports eligibility determinations using the modified adjusted gross income (MAGI) methodology for certain medical assistance applicants and enrollees (mainly children, parents, pregnant women, and adults without children); for MinnesotaCare applicants and enrollees; and for people applying for or enrolled in a qualified health plan. **Subd. 2. Establishment; committee membership.** Establishes the Minnesota Eligibility System Executive Steering Committee and specifies committee membership: one member appointed by the commissioner of human services, one member appointed by the MNsure board, one member

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
	• House has reference to MN.IT operating under chapter 16E • Senate has immediate effective date • Also technical differences (House Article 3, sections 2 and 11 are related provisions)	representing counties, and one nonvoting member representing MN.IT. Requires steering committee costs to be paid from the budgets of the Department of Human Services, MN.IT, and MNsure. **Subd. 3. Duties.** Directs the steering committee to establish a governance structure for the Minnesota eligibility system and to be responsible for the system's governance. Requires quarterly reports to the Legislative Oversight Committee, and requires the steering committee to adopt bylaws, policies, and agreements to administer the Minnesota eligibility system. **Subd. 4. Meetings.** Requires steering committee meetings to be held in the State Office Building and to be available for viewing through the legislature's Web site. Requires the steering committee to provide opportunities for public testimony at every meeting and to post meeting documents to the legislature's Web site. Requires steering committee votes to be recorded, with each member's vote identified. **Subd. 5. Administrative structure.** Lists duties of the Office of MN.IT Services for the Minnesota eligibility system.
Section 24 (62V.05, subd. 2) requires MNsure to retain or collect up to 1.5 percent of total premiums for individual health plans and dental plans sold to Minnesota residents through MNsure and outside of MNsure to fund the operations of MNsure beginning January 1, 2018. (Currently MNsure retains up to 3.5 percent of total premiums for individual and	Senate sets premium assessment at 1.5 percent of premiums for policies both inside and outside the exchange, effective 1-1-18, and excludes small group plans from this calculation. House reduces assessment to 1.75 percent of premiums for policies sold through the exchange, effective 1-1-17, and continues to include small group plans in this calculation. Effective 1-1-18, House	**A3, § 6. Operations funding.** Amends § 62V.05, subd. 2. Strikes paragraphs that established MNsure funding and authorized cash flow assistance in prior calendar years. Establishes the following funding structure for MNsure for current and future calendar years. Paragraph (a): For calendar year 2016 only, allows MNsure to retain up to 3.5 percent of total premiums for individual and

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
small group market health plans and dental plans sold through MNsure).	sets assessment at 1.75 percent if specified performance criteria are met, with a reduction to 1.5 percent if the criteria are not met. House sets limit of 60 percent of the MCHA assessment for CY 2012; Senate retains the current law limit of 100 percent. House also strikes outdated language related to the assessment phase-up.	small group market health plans and dental plans sold through MNsure. Paragraph (b): For calendar year 2017, allows MNsure to retain up to 1.75 percent of total premiums for plans sold through MNsure. Paragraph (c): For calendar year 2018 and subsequent calendar years, allows MNsure to retain up to 1.75 percent of total premiums for plans sold through MNsure, if an independent third party certifies that MNsure satisfied the listed benchmarks in the previous calendar year. Paragraph (d): For calendar year 2018 and subsequent calendar years, if an independent third party does not certify that MNsure met the benchmarks in paragraph (c), allows MNsure to retain up to 1.5 percent of total premiums for plans sold through MNsure. Paragraph (f): Lowers the ceiling for the total amount MNsure may retain to fund its operations, from 100 percent to 60 percent of funds collected in MCHA member assessments in calendar year 2012. **Effective date.** Makes this section effective July 1, 2016.
	House only	**A3, § 8. Legislative enactment required.** Amends § 62V.05, by adding subd. 12. (a) Prohibits the MNsure board from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the board from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines "state department" and "state agency." **Effective date.** Provides an immediate effective date.
	House only	**A3, § 9. Limitation on appropriations and transfers.** Amends § 62V.05 by adding subd. 13. Prohibits money from any state fund or account from being appropriated or made available to MNsure, or transferred or provided to MNsure by any state agency or entity of state government, unless the appropriation, transfer, or transaction is specifically authorized through enactment of a new law.
	House only	**A1, § 1. Additional notice to applicants.** Adds § 62V.055. Requires the MNsure board, in consultation with the commissioner of human services, to include in the combined application for MA, MinnesotaCare, and qualified health plan coverage available through the MNsure portal, information and notice on: (1) the order in which eligibility for health care programs will be determined; (2) that persons eligible for MA are not eligible for MinnesotaCare, and that persons eligible for MA or MinnesotaCare are not eligible for advanced premium tax credits and cost-sharing subsidies; and (3) that the state may claim repayment from the estates of MA enrollees, for the cost of medical care or premiums paid for that care.

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
	House only Technical amendment needed: cross-reference should read 62V.056.	**A3, § 11. Review of Minnesota eligibility system funding and expenditures.** Amends § 62V.11, by adding subd. 5. Requires the Legislative Oversight Committee to review quarterly reports submitted by the steering committee related to Minnesota eligibility system funding and expenditures.
	House only	**A3, § 12. Legislative enactment required.** Amends § 144.05, by adding subd. 6. (a) Prohibits the commissioner of health from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines "state department" and "state agency." **Effective date.** Provides an immediate effective date.
	House only	**A3, § 13. Legislative enactment required.** Amends § 256.01, by adding subd. 41. (a) Prohibits the commissioner of human services from entering into or renewing any interagency agreement or service level agreement, or related agreements, with a value of more than $100,000 a year, with any state department, state agency, or the Office of MN.IT Services, unless this is authorized by enactment of a new law. Provides that agreements without a specific expiration date

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		expire two years from the effective date of this section or of the agreement, unless authorized by enactment of a new law. (b) Prohibits the commissioner from transferring appropriations and funds in amounts over $100,000 across agency accounts or programs, unless this is authorized by enactment of a new law. (c) Defines "state department" and "state agency." Provides an immediate effective date.
Section 25 (256.01, subd. 41) requires the commissioner and the MNsure Board by January 15, 2017, to develop a plan and timetable to ensure the implementation of qualifying life events and changes in circumstances are processed within 30 days of receiving a report of the qualifying life event or change in circumstances by persons who have been determined eligible for a public health care program or are enrolled in a qualified health plan through MNsure.	Senate requires plan and implementation timetable to be developed by 1-1-17; House requires implementation of procedures by 9-1-16. House defines qualifying life event and requires communication with, and training of, county staff. Differences in terminology, phrasing, and section coding.	**A3, § 7. Processing qualifying life events and changes in circumstances.** Amends § 62V.05, by adding subd. 4a. Requires the MNsure Board and commissioner of human services to jointly develop procedures to require qualifying life events and changes in circumstances to be processed within 30 days of the qualifying life event or change in circumstances being reported. Requires the procedures to be developed and implemented by September 1, 2016, and requires the commissioner to communicate the procedures to county staff and provide necessary training and guidance to county staff. Specifies what constitutes a qualifying life event or change in circumstances.
Section 26 (256B.04, subd. 14) includes allergen-reducing products to the items that the Commissioner of Human Services may use for volume-purchasing through competitive bidding and negotiations under chapter 16C.	Senate only (Related to Senate section 41)	
	House only	**A1, § 10. Additional notice to applicants.** Amends § 256B.042, by adding subd. 1a. Requires applications for MA to include a statement, prominently displayed, that the state may claim repayment from the estates of MA enrollees for the cost of medical care or premiums paid for care.

SENATE

HOUSE

Article 25: Health Care		Articles 1, 2, and 3
	House only	**A2, § 1. Improved oversight of MNsure eligibility determinations.** Adds § 256B.0562. **Subd. 1. Implementation of OLA findings.** (a) Requires the commissioner of human services to ensure that MA and MinnesotaCare eligibility determinations through the MNsure information technology system fully implement the recommendations of the Office of Legislative Auditor (OLA) in reports 14-22 and 16-02. (b) Allows the commissioner to contract with a vendor for technical assistance in fully implementing the OLA report findings. (c) Requires the commissioner to coordinate implementation of this section with periodic data matching. (d) Requires the commissioner to use existing resources to implement this section. **Subd. 2. Duties of the commissioner.** (a) Lists the OLA report recommendations that the commissioner must fully implement. (b) Requires the commissioner to implement the OLA recommendations for MA and MinnesotaCare applications and renewals submitted on or after July 1, 2016. Requires the commissioner to submit quarterly reports to the legislative committees with jurisdiction over health and human services policy and finance that provide information on: (1) progress in implementing the OLA recommendations; (2) the number of

SENATE

HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		applicants and enrollees affected by implementation; and (3) savings to the state. Requires the quarterly report submitted October 1, 2016, to include a timetable for full implementation of the OLA recommendations. **Subd. 3. Office of Legislative Auditor.** Requires the legislative auditor to review each quarterly report for accuracy and review compliance by DHS with the OLA report recommendations. Requires the legislative auditor to notify legislative committee on whether or not these requirements are met. **Subd. 4. Special revenue account; use of savings.** (a) Establishes a medical assistance audit special revenue account in the general fund. Requires the commissioner to deposit into this account: (1) all savings from implementing the OLA recommendations; (2) all savings from implementing periodic data matching that are above the forecasted savings; and (3) all savings from implementing the vendor contract for eligibility verification under section 256B.0563, minus any payments made to the vendor under the revenue sharing agreement, (b) Requires the commissioner to provide a one-time payment increase to long-term care providers, once the balance in the fund is sufficient. (c) States that further expenditures from the account are subject to legislative authorization. **Effective date.** Provides an immediate effective date.

SENATE

HOUSE

Article 25: Health Care		Articles 1, 2, and 3
	House only	**A2, § 2. Eligibility verification.** Adds § 256B.0563. **Subd. 1. Verification required; vendor contract.** (a) Requires the commissioner to ensure that MA and MinnesotaCare eligibility determinations through MNsure and agency eligibility determination systems include the computerized verification of income, residency, identity, and assets. (b) Directs the commissioner to contract with a vendor to verify the eligibility of all persons enrolled in MA and MinnesotaCare during a specified audit period. Provides an exemption from state procurement provisions related to the use of state employees, and any other law to the contrary. (c) States that the contract must require the vendor to comply with enrollee data privacy requirements and use encryption, and provide penalties for vendor noncompliance. (d) Requires the contract to include a revenue sharing agreement under which vendor compensation is limited to a portion of the savings resulting from the vendor's implementation of eligibility verification initiatives. (e) Requires the commissioner to use existing resources to fund any administrative and technology-related costs incurred as a result of implementing this section. **Subd. 2. Verification process; vendor duties.** (a) Requires the verification process to include, but not be limited to, data matches of the name, date of birth, address, and Social Security number of enrollees against federal and state data sources, including the

SENATE

HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		ACA federal hub. Requires the vendor, to the extent feasible, to incorporate in the verification process procedures that are compatible and coordinated with, and build upon or improve, procedures used by existing state systems. (b) Requires the vendor to notify the commissioner of preliminary determinations, and requires the commissioner to accept or reject determinations within 20 business days. States that the commissioner retains final authority over determinations and requires the vendor to keep a record of all preliminary determinations of ineligibility. (c) Requires the vendor to recommend to the commissioner an eligibility verification process that will allow ongoing verification of enrollee eligibility under the MNsure and state agency eligibility determination systems. (d) Requires the commissioner and the vendor to jointly submit an eligibility verification report to legislative committees. Specifies report criteria. (e) Provides that the vendor contract is for an initial one-year period, and allows the commissioner to renew the contract for up to three additional one-year periods, and to require additional eligibility verification audits, if the commissioner or the legislative auditor determine that the MNsure and agency eligibility determination systems cannot effectively verify eligibility.

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 27 (256B.057, subd. 13) requires the commissioner to establish a process for federally qualified health centers to determine presumptive eligibility for medical assistance for patients who are pregnant women or children under the age of two and have a basis for eligibility using the modified adjusted gross income methodology.	Senate only	
Section 28 (256B.059, subd. 1) strikes the definition of "spousal share" thereby removing the requirement that a community spouse be allowed to retain only half of the marital assets up to a limit. Under the new language, a community spouse will be able to retain 100 percent of marital assets up to a limit. This section is effective June 1, 2016.	Senate only	
Section 29 (256B.059, subd. 2) modifies when a couple's assets are assessed and the moment in time that is used in that assessment by eliminating the references to the first day of a continuous period of institutionalization. Under the new language, marital assets are assessed upon application for MA long-term services. This section is effective June 1, 2016.	Senate only	
Section 30 (256B.059, subd. 3) sets the maximum value of assets a community spouse may retain at $119,220. The maximum current value is also $119,220 (after adjusting for inflation) but under the existing language, a community spouse can retain only one-half of the allowable marital assets, not 100 percent as is proposed under this section. This asset limit is subject to annual inflation adjustments. This section is effective June 1, 2016.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 31 (256B.059, subd. 5) eliminates unnecessary language. Under the new language, the assets available to a spouse receiving long-term care to pay for those services are all available assets after deducting the community spouse's asset allowance. This section is effective June 1, 2016.	Senate strikes references to the spousal share division and the requirement that asset evaluation take place following the first continuous period of institutionalization, and makes related changes. House provides that retirement and education related assets owned by the community spouse, in excess of the current law spousal share, may be retained by that spouse in cases of hardship.	**A1, § 11. Asset availability.** Amends Minnesota Statutes 2015 Supplement, § 256B.059, subd. 5. Allows an institutionalized spouse to maintain medical assistance eligibility when excess assets owned by the community spouse are retirement funds or funds protected for post-secondary education of a child under age 25. Provides that the retirement accounts are protected until the community spouse is eligible to withdraw funds without penalty. Requires that denial of eligibility must cause an undue hardship to the family. Provides that there shall not be an assignment of spousal support or a cause of action against the spouse for funds protected in retirement and college savings accounts. **Effective date.** Provides a June 1, 2016, effective date.
Section 32 (256B.059, subd. 6) expands the definition of "institutionalized spouse" to include (1) effective June 1, 2016, a spouse applying after June 1, 2016, for HCBS waiver services (2) effective March 1, 2017, a spouse enrolled prior to June 1, 2016, to receive HCBS waiver services and (3) effective June 1, 2016, a spouse applying for community first services and supports.	Senate only	
Section 33 (256B.06, subd. 4) requires emergency medical assistance to cover kidney transplants for persons with end-stage renal disease, who are currently receiving dialysis services, and who are a potential candidate for a kidney transplant.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 34 (256B.0625, subd. 9c) specifies that medical assistance covers oral health assessments if the assessment uses the risk factors established by the commissioner and is conducted by a licensed dental provider in collaborative practice to identify possible signs of oral or systemic disease, malformation or injury, and the need for referral for diagnosis and treatment.	Senate only	
Section 35 (256B.0625, subd. 17a) increases the medical assistance payment rates by five percent for ambulance services provided by ambulance service providers whose base of operations is located outside the metropolitan counties and outside the cities of Duluth, Mankato, Moorhead, St. Cloud, and Rochester, or within a municipality with a population of less than 1,000.	Senate requires managed care and county-based purchasing plans to pass on the full amount of the increase to providers. Technical difference in language specifying which providers are eligible for the increase (staff recommend Senate).	**A2, § 3. Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective July 1, 2016, increases MA payment rates for ambulance services by 5 percent, for ambulance service providers that: (1) have a base of operations located outside the seven-county metropolitan area, and outside Duluth, Mankato, Moorhead, St. Cloud, and Rochester; or (2) have a base of operations located within a municipality with population of less than 1,000. Requires capitation payments to managed care and county-based purchasing plans for ambulance services provided on or after January 1, 2017, to be adjusted to reflect the rate increase.
Section 36 (256B.0625, subd. 30) requires the commissioner to seek a section 1115 federal waiver in order to obtain enhanced federal financial participation at 100 percent federal match available to Indian health services facilities or tribal organization facilities for expenditures made for organizations that are dually certified under the Indian Health Care Improvement Act and as a federally qualified health center that provide services to eligible American Indians and Alaskan Natives.	Senate only	
Section 37 (256B.0625, subd. 31) specifies that the allergen products described in section 256B.0625, subdivision 65, shall be considered durable medical equipment.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 38 (256B.0625, subd. 34) specifies that the medical assistance payments to a dually certified facility under section 256B.0625, subd. 30, paragraph (j), shall be the encounter rate or a rate equivalent for services provided to American Indians and Alaska Native populations.	Senate only	
Section 39 (256B.0625, subd. 58) increases the payment rate for early and periodic screening, diagnosis, and treatment (EPSDT) screenings by five percent.	Senate only	
Section 40 (256B.0625, subd. 60a) adds community emergency medical technician (CEMT) services to the set of covered benefits under medical assistance by: • establishing CEMT services as a covered benefit; • establishing and describing a CEMT posthospital discharge visit as a CEMT service; • establishing and describing a CEMT safety evaluation visit as a CEMT service; and • establishing the provider rate for CEMT services.	Identical, except for technical differences in paragraph (c) (grammatical) and effective date (revisor notice). (Staff recommend Senate, with technical amendment to paragraph (c)).	**Community emergency medical technician services.** Amends § 256B.0625, by adding subd. 60a. (a) Provides medical assistance (MA) coverage of services provided by a community medical response emergency medical technician (CEMT) who is certified by the Emergency Medical Services Regulatory Board under § 144E.275, subdivision 7, when the services are provided according to this subdivision. (b) Allows a CEMT to provide a hospital discharge visit when ordered by a treating physician. Specifies the criteria for a visit. (c) Allows CEMTs to provide safety evaluation visits to individuals who have repeat ambulance calls due to falls, have been discharged from a nursing home, or have been identified by their primary care provider as at risk for nursing home placement. Requires the visit to be ordered by a primary care provider in accordance with the individual's care plan. Specifies criteria for visits. (d) Requires CEMTs to be paid at $9.75 per 15 minute increment. Provides that a safety evaluation visit cannot be

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		billed for the same day as a posthospital discharge visit for the same recipient. **Effective date.** Provides that the section is effective July 1, 2017, or upon federal approval, whichever is later.
Section 41 (256B.0625, subd. 65, paragraph (a) requires medical assistance to cover enhanced asthma care services and related products for children with poorly controlled asthma. Requires a child to meet the following criteria in order to be eligible for these services and products. The child must: 1. be under the age of 21; 2. have poorly controlled asthma; 3. have received health care for asthma from a hospital emergency department at least one time in the past year or been hospitalized for the treatment of asthma at least once in the past year; and 4. received a referral for these services and products from a treating health care provider. **Paragraph (b**) lists the covered services and products, which includes: a home assessment conducted by a healthy homes specialist; targeted asthma education services; and allergen reducing products. **Paragraph (c)** states that a child is limited to one home assessment and one visit by a certified asthma educator on how to use and maintain the allergen reducing products. Permits an additional home assessment if the child moves into a new house, a new trigger enters the	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
home, or the child's provider identifies a new allergy for the child. **Paragraph (d)** requires the commissioner to determine the frequency with which products may be replaced based on the reasonable expected lifetime of the product.		
	House only	**A2, § 5. Reimbursement under other state health care programs.** Amends § 256B.0644. Exempts dental providers providing services outside of the seven-county metropolitan area from the requirement that they participate as providers in MA and MinnesotaCare in order to participate as providers in the state employee health program, the public employees insurance program, and other programs of health coverage (Rule 101).
Section 42 (256B.15, subd. 1) makes a conforming change to the estate recovery language by striking a reference to the "total" cost of medical assistance an individual receives.	Senate only	
Section 43 (256B.15, subd. 1a, paragraph e) retroactively modifies the circumstances under which the Commissioner of Human Services is permitted to file a claim against the estate of an individual who received medical assistance *while not residing in an institution*. For services rendered prior to January 1, 2014, a claim against an estate must be filed if: (1) a person received any medical assistance and the person was 55 years old or older at the time the service was rendered; or (2) the person at any age resided in an institution for six months or longer. For services rendered after January 1, 2014, a claim against an estate must be filed, but only if: (1) the person was 55 years old or older at the time the service was rendered and the	Similar – both bodies limit recovery from persons age 55 plus to long-term care services. Senate includes a cross-reference to claim amounts being limited under subd. 2 and provides that section is effective for claims not paid prior to 7-1-16. Also a technical difference in effective date (House specifies retroactive application). (Staff recommend House.)	**A1, § 12. Estates subject to claims.** Amends § 256B.15, subd. 1a. Limits claims against the estate of a person over 55 years of age who did not receive institutional services to the amount of medical assistance correctly paid on behalf of the individual prior to January 1, 2014. Clarifies that claims against the estates of individuals age 55 or older who received nursing facility services, home and community-based services, or related hospital and prescription drug benefits on or after January 1, 2014, are allowed. **Effective date.** Provides that this section is effective upon federal approval and applies retroactively to services rendered on or after January 1, 2014.

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
services provided were nursing home services, home and community-based services, or related hospital and prescription drug benefits; or (2) the person at any age resided in an institution for six months or longer.		
	House only	**A1, § 13. Amending notices or liens arising out of notice.** Amends § 256B.15, by adding subd. 1l. Instructs state agencies to amend notices of potential claims and liens for notices filed on or after January 1, 2014, for medical assistance services provided to individuals age 55 and older who were not institutionalized. **Effective date.** Provides that this section is effective the day following final enactment.
Section 44 (256B.15, subd. 2 – Limitations on claims) specifies what costs may be included in a claim against an estate. For services rendered prior to January 1, 2014, a claim must include only (1) the total cost of medical assistance rendered after age 55, and (2) the total cost of medical assistance rendered at any age during a period of institutionalization. For services rendered after January 1, 2014, a claim must include only (1) the total cost of nursing home services, home and community-based services, and related hospital and prescription drug benefits rendered after age 55, and (2) the total cost of medical assistance rendered at any age during a period of institutionalization.	Similar. Technical difference in cross-reference (staff recommend House). Senate provides that section is effective for claims not paid prior to 7-1-16. Technical differences in cross-references (staff recommend Senate).	**A1, § 14. Limitations on claims.** Amends § 256B.15, subd. 2. Paragraph (a) adds language to clarify that this paragraph applies to services rendered prior to January 1, 2014. Paragraph (b) provides that claims for services rendered on or after January 1, 2014, must only include nursing facility services, home and community-based services, or related hospital and prescription drug benefits provided for individuals age 55 or older. States that claims must not include interest. **Effective date.** Provides that this section is effective upon federal approval and applies to services rendered on or after January 1, 2014.
Section 45 (256B.69, subd. 6) specifies that managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.83, for purposes of delivering services under the prepaid medical assistance program.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 46 (256B.76, subd. 1) increases the payment for primary care services by five percent when provided by a physician certified in family medicine, general internal medicine, pediatric medicine, or obstetric and gynecological medicine; or a physician assistant, advanced practice registered nurse, or physician other than a psychiatrist for whom at least 60 percent of the services for which they received payment under medical assistance or MinnesotaCare were for primary care evaluation and management services or vaccine administration services.	Senate only	
Section 47 (256B.76, subd. 2) Paragraph (l) specifies that effective January 1, 2017, payment rates for dental services provided outside the seven-county metropolitan area are increased by 9.65 percent. This replaces the payment rate increase for dental services that was passed last session that applied to dental services furnished by dental providers located outside of the seven-county metropolitan area. **Paragraph (m)** specifies that effective for services provided on or after July 1, 2016, payment rates for preventive dental services are increased by five percent.	Paragraph (l): House applies the 1-1-17 rural rate increase to rates in effect on 6-30-15 (both bodies sunset a rate increase that took effective 7-1-15). Senate requires plans to pass through increase to providers. Paragraph (m): Rate increase for preventive dental services is Senate only.	**A2, § 6. Dental reimbursement.** Amends § 256B.76, subd. 2. Effective January 1, 2017, increases MA payment rates by 9.65 percent above the rates in effect on June 30, 2015, for dental services provided outside the seven-county metropolitan area. States that the increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2017, requires payments to managed care and county-based purchasing plans to reflect this payment increase. Also sunsets, on January 1, 2017, a rate increase for dental providers located outside the seven-county metropolitan area.
Section 48 (256B.76, subd. 4) Paragraph (a) modifies the medical assistance critical access dental payments from 35 percent to 37.5 percent, except as specified in paragraph (b). **Paragraph (b)** specifies that the critical access dental payment for dental clinics and dental groups that meet the critical access dental provider designation under paragraph (d), clause (4), and is owned and operated by a health maintenance organization shall remain at 35	Senate increases critical access dental provider add-on to 37.5 percent of the rate that would otherwise be paid, effective 7-1-16. House increases the add-on to 36 percent on 7-1-16 and 37 percent on 7-1-17. Otherwise identical.	**A2, § 7. Critical access dental providers.** Amends § 256B.76, subd. 4. (a) Increases critical access dental provider payment rates, except for those set under paragraph (b), to 36 percent above the rate that would otherwise apply, effective July 1, 2016, and to 37 percent above the rate that would otherwise apply, effective July 1, 2017. (The current rate enhancement is 35 percent.)

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
percent rate increase over what would otherwise be paid to the critical access provider. **Paragraph (c)** modifies the calculation used to determine the critical access dental payments. **Paragraph (d)** modifies the critical access dental provider designation so that the following dentists or dental clinics are included as critical access dental providers: nonprofit community clinics; hospital-based dental clinics owned and operated by a city, county, or former state hospital; dental clinics or dental groups owned and operated by a nonprofit corporation with more than 10,000 patient encounters per year with patients who are uninsured or covered by medical assistance or MinnesotaCare; and private practicing dentists if the dentist's office is located within the seven-county metropolitan area and more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare or is located outside the seven-county metropolitan and more than 25 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare.		(b) Retains the 35 percent enhanced critical access dental rate for dental clinics or dental groups owned and operated by an HMO that meets specified criteria. (c) Requires the critical dental provider payment rate for services provided to enrollees of a managed care or county-based purchasing plan to be calculated based on the plan's fee-for-service rate, rather than a capitated or cost-based payment rate. (d) Modifies criteria for critical access dental providers by: (1) including hospital-based dental clinics owned and operated by a former state hospital meeting specified criteria; and (2) broadening the criteria to include dentists in private practice located within the seven-county metropolitan area for whom more than 50 percent of patient encounters are with persons uninsured or covered by MA or MinnesotaCare and dentists located outside of the seven-county metropolitan area for whom more than 25 percent of patient encounters are with persons who are uninsured or covered by MA or MinnesotaCare. (Under current law, a dentist in private practice must be located in a health professional shortage area, meet the 50 percent patient encounter criteria, and provide a level of service critical to maintaining patient access.)
Section 49 (256B.761) increases payment rates for outpatient mental health services by five percent.	Senate only	
Section 50 (256B.7625) increases the payment rates for prenatal and postpartum follow up home visits provided by public health nurses using evidence-based models to $140 per visit effective January 1, 2017.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 51 (256B.766) clarifies the medical assistance rate increase that was passed last year for durable medical equipment and supplies.	Identical, except House has effective date section that specifies retroactive intent; Senate does not have an effective date section. (Staff recommend inclusion of House effective date section.)	**Reimbursement for basic care services.** Amends § 256B.766. The amendment to paragraph (i) strikes language requiring the MA payment rate for durable medical equipment, prosthetics, orthotics, or supplies to be restored to the January 1, 2008, MA fee schedule. Also prohibits the commissioner from applying any MA payment reductions to durable medical equipment as a result of Medicare competitive bidding. A new paragraph (j) increases the MA payment rate for durable medical equipment, prosthetics, orthotics, or supplies that were subject to the Medicare 2008 competitive bid by 9.5 percent effective July 1, 2015. Further increases payment rates for durable medical equipment, prosthetics, orthotics, or supplies on the MA fee schedule, whether or not they were subject to the Medicare 2008 competitive bid, by 2.94 percent. Exempts the following from this paragraph: items subject to volume purchase, products subject to the preferred diabetic testing supply program, certain items provided to dually eligible recipients, and individually priced items. States that managed care and county-based purchasing plan payments shall not be increased to reflect the rate increases in this paragraph. **Effective date.** Provides a retroactive effective date of July 1, 2015.
Section 52 (256L.01, subd. 1a) modifies the definition of child to an individual under the age of 21.	Senate only	
Section 53 (256L.01, subd. 5) modifies the definition of "income" to mean a household's current income, or if income fluctuates month to month, the income for the 12-month eligibility period.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 54 (256L.03, subd. 5) requires the commissioner to increase cost-sharing for covered services for enrollees with income greater than 200 percent, but not exceeding 250 percent so that the actuarial value for the MinnesotaCare benefit is 87 percent and for enrollees with income greater than 250 percent, but not exceeding 275 percent the actuarial value of the benefit is 80 percent.	Senate only	
Section 55 (256L.04, subd. 1) increases the income eligibility limit for MinnesotaCare from 200 percent to 275 percent for families with children.	Senate only	
Section 56 (256L.04, subd. 1a) requires individual and families applying to MinnesotaCare to provide a Social Security number if required under the federal regulations.	Senate only	
Section 57 (256L.04, subd. 2) makes it permissive for an individual or family to cooperate with the state to identify potentially liable third-party payers and assist the state in obtaining third-party payments or in establishing paternity and obtaining medical care support and payments for the child.	Senate only	
Section 58 (256L.04, subd. 7) increases the income eligibility limits for MinnesotaCare from 200 percent to 275 percent of federal poverty guidelines for single adults without children.	Senate only	
Section 59 (256L.04, subd. 7b) requires the commissioner to adjust the income limits annually each July 1 instead of January 1.	Senate only	
Section 60 (256L.05, subd. 3a) modifies the redetermination time period for MinnesotaCare so that the 12 month period begins the month of application and authorizes the commissioner to adjust the eligibility period for enrollees to implement renewals throughout the year.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 61 (256L.06, subd. 3) requires the commissioner to forgive the past due premium for individuals who are disenrolled for nonpayment of premiums before issuing a premium invoice for the fourth month following disenrollment.	Senate only	
Section 62 (256L.07 subd. 1) modifies the period in which disenrollment begins for individuals whose income increases above the income eligibility limit to the last day of the calendar month in which the commissioner sends advance notice in accordance with federal regulations.	Senate only	
Section 63 (26L.11, subd. 7) increases the critical access dental payments for MinnesotaCare from 30 percent to 32.5 percent above the payment the provider would otherwise be paid, except for the critical access dental providers described in section 256B.76, subdivision 4, paragraph (b), in which the payment shall remain at 30 percent above the payment the provider would otherwise be paid.	Senate only	
Section 64 (256L.15, subd. 1) requires the commissioner to accept an individual's attestation of the individual's status as an American Indian as verification until the federal government approves an electronic data source that purpose.	Senate only	
Section 65 (256L.15, subd. 2) requires the commissioner of human services, in consultation with the commissioners of health and commerce and the executive director of MNsure, to seek all necessary federal waiver authority to design and operate a seamless and sustainable health coverage continuum that reduces barriers, eases transition, and ensures access to comprehensive and affordable health care coverage. The waiver shall include proposals to expand MinnesotaCare income eligibility to 275 percent of federal poverty guidelines; offer continuous eligibility for families and children; address	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
the "family glitch;" establish a MinnesotaCare public option; and replace the annual open enrollment period with an alternative.		
Section 66 (Federal Waiver) requires the commissioner of human services, in consultation with the commissioners of health and commerce and the executive director of MNsure, to seek all necessary federal waiver authority to design and operate a seamless and sustainable health coverage continuum that reduces barriers, eases transition, and ensures access to comprehensive and affordable health care coverage. The waiver shall include proposals to expand MinnesotaCare income eligibility to 275 percent of federal poverty guidelines; offer continuous eligibility for families and children; address the "family glitch;" establish a MinnesotaCare public option; and replace the annual open enrollment period with an alternative.	Senate waiver would seek necessary federal authority to design and operate a seamless and sustainable health coverage continuum by: requesting to expand MinnesotaCare eligibility to 275 percent FPG; providing continuous 12-month MA eligibility for children and families; allowing certain persons with employer subsidized coverage to enroll in MinnesotaCare or access premium tax credits and cost sharing subsidies ("family glitch"); establishing a MinnesotaCare public option for persons with income over the MinnesotaCare income limit; and allowing for an alternative open enrollment period for the individual health plan market. House waiver (section 14) would allow persons to decline MinnesotaCare coverage and obtain premium tax credits and cost-sharing reductions for qualified health plans through MNsure or outside of MNsure. House waiver (section 15) would replace MNsure with a federal-state eligibility determination system, under which enrollment and eligibility for MA and MinnesotaCare would be conducted by DHS, and enrollment and eligibility for qualified health plans, premium tax credits, and cost-sharing reductions would be conducted by the federal exchange. House would also establish an asset test for adults without children under MA and MinnesotaCare.	**A3, § 14. Federal waiver.** Amends § 256L.02, by adding subd. 7. Directs the commissioner of human services to apply for an innovation waiver under section 1332 of the Affordable Care Act, or any other applicable federal waiver, to allow persons eligible for MinnesotaCare to decline MinnesotaCare coverage and instead access advanced premium tax credits and cost-sharing reductions by purchasing qualified health plans, either through MNsure or outside of MNsure through health plan companies. Requires the waiver request to be submitted within nine months of the effective date of this provision. Requires the commissioner to coordinate the waiver request with the waiver requested by the commissioner of commerce to allow individuals to purchase qualified health plans outside of MNsure directly from health plan companies, and receive advanced premium tax credits and cost-sharing reductions (required by Laws 2015, chapter 71, article 12, section 8). Requires the commissioner of human services to submit a draft waiver proposal to the MNsure board and legislative committees at least 30 days before submitting the final waiver proposal to the federal government, and to notify the board and legislative committees of any federal decision or action. If federal approval is granted, requires the commissioner to submit to the legislature draft legislation and fiscal estimates necessary to implement the proposal. **Effective date.** Provides an immediate effective date.

SENATE

HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		A 3, § 15. Federal-state eligibility determination and enrollment system for insurance affordability programs. Directs the commissioner of human services to seek a federal waiver to establish a federal-state eligibility determination and enrollment system. **Subd. 1. Waiver request.** (a) Requires the commissioner of human services, in consultation with the MNsure board and the commissioners of commerce and health, to apply for a federal section 1332 innovation waiver, or any other applicable waiver, to establish a federal-state eligibility determination and enrollment system for state insurance affordability programs, for coverage beginning January 1, 2018. States that the system shall take the place of MNsure. Specifies that under the system, eligibility determinations and enrollment for MA and MinnesotaCare shall be conducted by the commissioner, and eligibility determinations and enrollment for qualified health plans, advanced premium tax credits, and cost-sharing reductions shall be conducted by the federally-facilitated marketplace. (b) Defines "state insurance affordability programs." (c) Requires the system to incorporate an asset test for persons who qualify as adults without children under MA or MinnesotaCare. Specifies the asset limit as $10,000 in total net assets for a household of one and $20,000 for a household of two or more. **Subd. 2. Requirements of waiver application.** Requires the commissioner, in designing the eligibility determination and enrollment system and developing

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
		the waiver application, to: (1) incorporate, where appropriate and cost-effective, elements of the MNsure and DHS eligibility determination systems; (2) coordinate the waiver request with the waiver requests required by section 256L.02, subdivision 7 (allowing persons to decline MinnesotaCare and access tax credits and cost-sharing reductions) and Laws 2015, chapter 71, article 12, section 8 (allowing purchase of qualified health plans outside of MNsure and access to tax credits and cost-sharing reductions); (3) regularly consult with stakeholder groups; and (4) seek all available federal grants and funds for planning and development. **Subd. 3. Vendor contract; use of existing resources.** Requires the commissioner, in consultation with MN.IT, to contract with a vendor for technical assistance. Requires the commissioner to use existing resources in developing the waiver request and contracting for technical assistance. **Subd. 4. Reports to legislative committees.** Requires the commissioner to report to legislative committees, by January 1, 2017, on progress in seeking the waiver, and to notify legislative committees of any federal decision related to the waiver request. **Effective date.** Provides an immediate effective date.
Section 67 (Direction to the Commissioner; Notice) requires the Department of Human Services within 90 days of enactment to notify anyone who received medical assistance non long-term care services of the amendments to the estate recovery language in this bill.	Senate only	

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Section 68 requires the Commissioner of Management and Budget to develop a request for information to consider the feasibility for a private vendor to provide the technology functions for the individual market and small business health options program (SHOP) market currently provided by MNsure.	Senate only	
	House only	**A2, § 9. Prohibition on use of funds.** **Subd. 1. Use of funds.** Prohibits funding for state-sponsored health programs that are administered by the commissioner of human services from being used for funding abortions except to the extent necessary for continued participation in a federal program. (The health care programs administered by the commissioner of human services are medical assistance and MinnesotaCare.) Defines abortion. **Subd. 2. Severability.** Allows for severability of any one or more provisions of this section if any part is found to be unconstitutional.
	House only	**A3, § 16. Revisor's instruction.** Authorizes the revisor of statutes to change cross-references to statutes and rules that are repealed in this article, and to make any necessary technical changes to preserve the meaning of the text.
Section 69 (Repealer.) **Paragraph (a)** repeals obsolete language concerning the implementation of the rules governing the treatment of marital assets when a spouse is institutionalized effective June 1, 2016.	Senate repeals provisions related to treatment of marital assets under MA and provisions related to MinnesotaCare; House repeals provisions establishing and governing MNsure, contingent upon federal waiver approval.	**A3, § 17. Repealer.** Repeals the statutes and rules that establish and govern MNsure. Provides that this section is effective upon approval of the waiver request to establish and operate a federal-state eligibility determination and enrollment system, or January 1, 2018, whichever is later.

SENATE HOUSE

Article 25: Health Care		Articles 1, 2, and 3
Paragraph (b) repeals sections 256L.04, subd. 2a (application for other benefits); 256L.04, subd. 8 (applicants potentially eligible for medical assistance); 256L.22, 256L.24; 256L.26; 256L.28 (Children's Health program) effective the day following final enactment, effective the day following final enactment.		