Bill Summary Comparison of Health and Human Services

House

Senate File 760, 2nd Unofficial Engrossment

Article 5: Health Care

Senate

Senate File 760, 3rd Engrossment

Article 5: Health Care

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

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HOUSE SENATE

Section	Article 5: Health Care		Article 5: Health Care
1	**Freedom of choice in health care act.** Adds § 1.06. **Subd. 1. Citation.** States that the section may be known and cited as the "Freedom of Choice in Health Care Act." **Subd. 2. Definitions.** Defines the following terms: health care service, mode of securing, and penalty. **Subd. 3. Statement of public policy.** (a) States that the power to require or regulate a person's choice in the mode of securing health care services, or to impose a penalty related to that choice, is not found in the U.S. Constitution, and is a power reserved to the people and the states. Further states that Minnesota exercises its sovereign power to declare the public policy of the state regarding the right of persons to choose the mode of securing health care services. (b) Declares that it is the public policy of the state that every person within the state is, and shall be, free to choose or decline any mode of securing health care services, without penalty or threat of penalty. (c) Provides that the policy stated in this section shall not be applied to impair any right of contract related to the provision of health care services.	Similar. Differences are noted. Identical. Subd. 2 – Technical differences; staff recommend House. Identical.	**Section 1 (1.06)** establishes the Freedom of Choice in Health Care Act. **Subdivision 1** states that this section may be cited as the "Freedom of Choice in Health Care Act." **Subdivision 2** defines the following terms: "health care service," "mode of securing," and "penalty." **Subdivision 3, paragraph (a)**, states as public policy that the power to require or regulate a person's choice of in the mode of securing health care services or to impose a penalty related to that choice is not found in the U.S. Constitution and that the state hereby exercises its sovereign power to declare the right of all persons residing in the state in choosing the mode of securing health care services. **Paragraph (b)** declares that as a public policy of the state of Minnesota every resident is free to choose or decline to choose any mode of securing health care services without penalty or threat of penalty. **Paragraph (c)** states that this public policy is not to be applied to impair any right of contract related to the provision of health care services to any person or group.

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	Subd. 4. Enforcement. Upon penalty of suspension or revocation of any applicable license, prohibits any public official, employee, officer of the court, or agent of the state or any of its political subdivisions from imposing, collecting, enforcing, or effectuating any penalty in the state that violates the public policy specified in this section.	Subd. 4. House provides suspension or revocation of license as a penalty; Senate does not. Senate requires the Attorney General to take any action necessary to defend or prosecute the rights protected under this section; House does not. House refers to a "branch" of a political subdivision; Senate does not.	**Subdivision 4** states that no public official, employee, or agent of the state or any of its political subdivisions shall act to impose, collect, enforce, or effectuate any penalty that violates the public policy set forth in this section. This subdivision also requires the Attorney General to take any action as provided in this section or in Minnesota Statutes, section 8.31, to defend or prosecute the rights protected under this section.
		Senate-only provision.	**Section 2 (8.31, subdivision 1)** requires the Attorney General to seek injunctive and any other appropriate relief to preserve the rights and property of the residents of the state and to defend the state's officials, employees, and agents in the event that there is a law or regulation that violates the public policy as set forth in the Freedom of Choice in Health Care Act. This section also requires the Attorney General to seek injunctive and any other appropriate relief in the event that any law or regulation that violates the public policy of the Freedom of Choice in Health Care Act is enacted without adequate federal funding to the state to ensure affordable health care coverage is available to the residents of the state.
		Senate-only provision.	**Section 3 (8.31, subdivision 3a)** states that any person injured by a violation of the public policy in section 1.06 may bring a civil action and recover damages, cost and disbursements, and other equitable relief as determined by the court. This section also states that an action brought under this section for a violation of section 1.06 is in the public interest.

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2	**Establishment.** Amends § 62E.08, subd. 1. Provides that the MCHA premium for the high-deductible, basic plan offered under section 62E.121 shall range from 101 to 125 percent of the weighted average of rates for comparable plans offered outside of MCHA.	House-only provision.	
3	**High-deductible, basic plan.** Adds § 62E.121. **Subd. 1. Required offering.** Requires MCHA to offer a high deductible, basic plan that meets the requirements in this section. Specifies that the plan is a one-person plan and that dependents must be covered separately. **Subd. 2. Annual deductible; out-of-pocket maximum.** (a) Requires the plan to provide in-network annual deductible options of $3,000, $6,000, $9,000, and $12,000, with an in-network out-of-pocket maximum that is $1,000 greater than the amount of the annual deductible. (b) Provides an annual increase in the deductible, based on the change in the CPI. **Subd. 3. Office visits for nonpreventive care.** Specifies different levels of copayments for the first three nonpreventive office visits, depending upon the deductible option chosen. Provides 80 percent coverage for subsequent visits, after the deductible is met. **Subd. 4. Preventive care.** Provides 100 percent coverage for preventive care, with no cost-sharing.	House-only provision.	

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	Subd. 5. Prescription drugs. Requires a $10 copayment for preferred generic drugs, and requires enrollees to pay 100 percent of the plan's rate for preferred brand-name drugs. **Subd. 6. Convenience care center visits.** Requires a $20 copayment for the first three convenience center visits, with 80 percent coverage for subsequent visits after the deductible is met. **Subd. 7. Urgent care center visits.** Requires a $100 copayment for the first urgent care visit, and provides 80 percent coverage for subsequent visits after the deductible is met. **Subd. 8. Emergency room visits.** Requires a $200 copayment for the first emergency room visit, and provides 80 percent coverage for subsequent visits after the deductible is met. **Subd. 9. Lab and x-ray; hospital services; ambulance; surgery.** Provides that these services are covered at 80 percent after the deductible is met. **Subd. 10. Eyewear.** Pays $50 per calendar year for eyewear. **Subd. 11. Maternity.** Specifies that maternity, labor and delivery, and postpartum care are not covered. Provides 100 percent coverage for prenatal care with no deductible.		

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	Subd. 12. Other eligible health care services. Provides 80 percent coverage for other eligible health care services after the deductible is met. **Subd. 13. Option to remove mental health and substance abuse coverage.** Allows enrollees to remove mental health and substance abuse coverage and receive a reduced premium. **Subd. 14. Option to upgrade prescription drug coverage.** Allows enrollees to upgrade prescription drug coverage in return for an increased premium. **Subd. 15. Out-of-network services.** Provides that: the out-of-network deductible is twice the in-network annual deductible; there is no out-of-pocket maximum for out-of-network services; out-of-network benefits are covered at 60 percent after the deductible is met; and the lifetime maximum for out-of-network services is $1 million. **Subd. 16. Services not covered.** Lists services not covered by the plan.		
4	**Waiver of preexisting conditions for persons covered by healthy Minnesota contribution program.** Amends § 62E.14, by adding subd. 4f. Allows individuals to enroll in an MCHA plan with a waiver of the preexisting condition limit, if they are eligible for the healthy Minnesota contribution program and have been denied private sector coverage.	Similar, except Senate includes the medical assistance healthy Minnesota contribution program in the MCHA preexisting condition waiver.	**Section 4 (62E.14, subdivision 4f)** specifies that a person who is eligible for the Healthy Minnesota Contribution Program under Minnesota Statutes, section 256B.695 or 256L.031, may enroll in MCHA with a waiver of the preexisting condition limitation if the person has been denied coverage in the individual market.

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5	**Growth limits; federal programs.** Amends § 62J.04, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.	House-only provision.	
		Senate-only provision. (Senate needs an amendment to section 256B.69, subd., 5c, that makes a corresponding change in that section if the Senate position is adopted.)	**Section 5 (62J.692, subdivision 7)** eliminates a portion of the medical education and research **(MERC)** payments from the PMAP carve out.
6	**Review of eligible providers.** Amends § 62J.692, subd. 9. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.	House-only provision.	
7	**Billing for procedures to correct medical errors is prohibited.** Adds § 62J.824. Prohibits a health care provider from billing and being reimbursed for any service provided to reverse, correct, or otherwise minimize the effects of an adverse health event for which the health care provider is responsible.	House-only provision.	
8	**Local ombudsperson.** Amends § 62Q.32. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.	House-only provision.	
9	**Payment to out-of-network providers.** Allows a health plan company to limit payments to out-of-network providers to the usual and customary rate that applies to in-network providers.	House-only provision.	
10	**Provider peer grouping.** Amends § 62U.04, subd. 3. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.	House-only provision.	

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11	**Uses of information.** Amends § 62U.04, subd. 9. Requires information on provider cost and quality to be used by government and the private sector for product renewals or new products, after 12 months have elapsed from publication by the commissioner of this information.	House-only provision.	
12	**Legislative oversight.** Amends § 62U.06, subd. 2. Makes a conforming change related to the elimination of the Legislative Commission on Health Care Access.	House-only provision.	
13	**Performance payments.** Amends § 256.01, subd. 2b. Strikes language requiring the commissioner to develop and implement a performance payment system for eligible medical groups and clinics serving state health care program enrollees with chronic diseases.	House-only provision.	
14	**Contingency contract fees.** Amends § 256.01, by adding subd. 33. When the commissioner enters into a contingency-based contract for the purpose of recovering MA or MinnesotaCare funds, allows the commissioner to retain that portion of recovered funds equal to the amount of the contingency fee.	Identical.	**Section 6 (256.01, subdivision 33)** implements federal program integrity audits and authorizes the commissioner to retain the contingency state share of recoveries in order to implement a contract with a vendor for the audits.
15	**Elimination of certain provider reporting requirements; sunset of new requirements.** Amends § 256.01, by adding subd. 34. Requires the commissioner of human services, effective July 1, 2012, to cease collecting reports and data from health care providers, unless this is necessary for federal compliance. Requires the commissioner to present to the 2012 legislature draft legislation to repeal reporting requirements not necessary for federal compliance. Allows the commissioner to propose to the legislature for enactment new provider reporting	House-only provision.	

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	requirements, to take effect on or after July 1, 2012. Requires these new requirements to sunset after five years, unless they are renewed by the commissioner.		
16	**Operating payment rates.** Amends § 256.969, subd. 2b. Delays hospital rebasing for the first six months of the rebased period beginning January 1, 2013.	Identical.	**Section 7 (256.969, subdivision 2b)** delays rebasing of hospital rates under medical assistance (MA) for six months.
17	**Initiatives to reduce incidence of low birth-weight.** Amends § 256.969, by adding subd. 31. Requires hospitals located in the seven-county metropolitan area to implement strategies to reduce the incidence of low-birth weight in geographic areas with a higher than average incidence of low-birth weight. Specifies criteria for initiatives and requires implementation by July 1, 2012. Requires the commissioner to evaluate the strategies.	House-only provision.	
18	**Applications for medical assistance.** Amends § 256B.04, subd. 18. Requires the commissioner to modify the Minnesota health care programs application form to add a question asking applicants if they are U.S. military veterans.	Identical.	**Section 8 (256B.04, subdivision 18)** requires the Commissioner of Human Services to modify the Minnesota health care programs application form to ask applicants if they are U.S. military veterans.
19	**Technical assistance.** Amends § 256B.05, by adding subd. 4. Requires the commissioner, using existing resources, to provide technical assistance to county agencies in processing complex MA applications.	House-only provision.	
20	**Adults without children.** Amends § 256B.055, subd. 15. Requires the commissioner to eliminate MA coverage for adults without children, and suspend new enrollment, if the federal government eliminates or reduces the federal Medicaid match for this group.	Senate repeals MA coverage for adults without children. House provides for contingent repeal if the federal government eliminates or suspends federal match for this group, but also repeals the provision January 1, 2012, (see section 123).	See Repealer section.

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21	**Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Strikes language stating that MA enrollees who are adults with no children have no asse**t** limit (related to repeal of coverage for this group)**.**	House-only provision (but Senate achieves same effect by repealing the relevant session law provision in section 53, paragraph (c)).	
22	**Income.** Amends § 256b.056, subd. 4. Strikes language specifying the income limit for MA enrollees who are adults with no children (related to repeal of coverage for this group).	House-only provision (but Senate achieves same effect by repealing the relevant law provision in section 53, paragraph (c)).	
23	**Citizenship requirements.** Amends § 256B.06, subd. 4. Clarifies services covered under emergency MA, by specifying that various services, including those related to chronic conditions, are not covered.	Identical in terms of limiting coverage for emergency medical conditions. Senate also eliminates state funded coverage for certain noncitizens.	**Section 9 (256B.06, subdivision 4)** eliminates state-funded medical assistance coverage for legal noncitizens, and limits coverage under the emergency medical assistance program.
24	**Care coordination services provided through pediatric hospitals.** Amends § 256B.0625, by adding subd. 1b. Provides MA coverage for care coordination services provided by certain pediatric hospitals to children with high-cost medical conditions or at risk of recurrent hospitalization for acute or chronic illness. Defines and sets criteria for Level I pediatric care coordination services (those provided by advanced practice nurses employed by, or under contract with, certain pediatric hospitals), and Level II pediatric care coordination services (those provided by registered nurses employed by or under contract with a pediatric hospital designated as an essential community provider and which meets other criteria). Requires managed care and county-based purchasing plan rates to be adjusted to reflect savings from coverage of these services.	House-only provision.	

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25	**Evidence-based childbirth program.** Amends § 256B.0625, by adding subd. 3g. Requires the commissioner to implement a program to reduce the number of elective inductions of labor prior to 39 weeks gestation. For births covered by MA or MinnesotaCare on or after January 1, 2012, prohibits payments for professional services associated with a delivery unless certain information is submitted to the commissioner. Exempts from this requirement deliveries performed at hospitals that have policies and processes in place to prohibit elective inductions prior to 39 weeks gestation, that have been approved by the commissioner. Allows the commissioner to not implement or discontinue the program, if the commissioner determines that at least 90 percent of MA and MinnesotaCare births occur at hospitals that have approved policies.	Identical, except for statutory coding.	**Section 25 (256B.0625, subdivision 56)** requires the commissioner to implement a program to reduce the number of elective inductions of labor prior to 39 weeks' gestation in the MA and MinnesotaCare programs.
		Senate-only provision.	**Section 11 (256B.0625, subdivision 3h)** eliminates MA coverage for podiatric services.
		Senate-only provision.	**Section 12 (256B.0625, subdivision 8)** eliminates physical therapy for adults and requires authorization before services are provided to children. This section also changes the authorization system for those services.
		Senate-only provision.	**Section 13 (256B .0625, subdivision 8a)** eliminates occupational therapy for adults and requires authorization before services are provided to children. This section also changes the authorization system for those services.
		Senate-only provision.	**Section 14 (256B.0625, subdivision 8b)** eliminates speech-language pathology for adults and requires authorization before services are provided to children. This section also changes the authorization system for those services.

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		Senate-only provision.	**Section 15 (256B.0625, subdivision 8c)** modifies rehabilitation services for physical therapy, occupational therapy, and speech-language pathology and audiology services, by requiring prior authorization for an episode of treatment. Authorization for services shall include approval for up to six months, instead of 12 months. This section also changes the authorization system for those services.
26	**Chiropractic services.** Amends § 256B.0625, subd. 8e. Increases from 12 to 24 the number of chiropractic visits allowed before prior authorization is required.	Senate repeals this subdivision eliminating chiropractic services as a covered service and adds a new subdivision specifying that chiropractic services are not covered. House increases the number of visits allowed before prior authorization.	**Section 10 (256B.0625, subdivision 3g)** eliminates chiropractic services in MA. See also Repealer section.
27	**Acupuncture services.** Amends § 256B.0625, by adding subd. 8f. Provides that MA covers acupuncture, only when provided by a licensed acupuncturist, or by a practitioner for whom acupuncture is within scope of practice and who has specific acupuncture training or credentialing.	House-only provision.	
		Senate-only provision.	**Section 16 (256B.0625, subdivision 12)** eliminates MA coverage for eyeglasses, dentures, and prosthetic devices for adults.
28	**Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) converts MA payment for drug ingredient costs from a formula based on average wholesale price (AWP) to one based on wholesale acquisition cost (WAC). Sets payments at WAC plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at WAC plus two percent for all other pharmacies. Also strikes payment language related to antihemophilic factor drugs.	Paragraph (a) difference in the pharmacy reimbursement rate: House: WAC plus four percent for independently owned pharmacies located in rural areas; WAC plus two percent for all other pharmacies. Senate: WAC plus two percent for all pharmacies.	**Section 17 (256B.0625, subdivision 13e), paragraph (a),** modifies the pharmacy reimbursement rate methodology from Average Wholesale Price to methodology based on wholesale acquisition cost (WAC) plus two percent.

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	The amendment to paragraph (d) sets payment rates for drugs administered in an outpatient setting at the lower of the usual and customary cost or 106 percent of the average sales price. Payment under current law is at the lower of the usual and customary cost or the amount established by Medicare.	Paragraph (d): Identical.	**Paragraph (d)** sets payment rates for drugs administered in an outpatient setting at the lower of the usual and customary cost or 106 percent of the average sales price as determined by the federal Department of Health and Human Services. If the average sale price is unavailable, the amount shall be the lower of the usual and customary cost submitted by the provider or the WAC.
	The amendment to paragraph (e) includes antihemophilic factor products in the list of specialty pharmacy products for which the commissioner may negotiate lower reimbursement rates and require enrollees to obtain from providers that have agreed to the lower rates. Provides an effective date of July 1, 2011, or upon federal approval.	Paragraph (e): Identical. House effective date adds reference to federal approval.	**Paragraph (e)** includes antihemophilic factor products in special pharmacy products in which the commissioner may negotiate lower reimbursement rates and may require enrollees to obtain these products from providers that have agreed to the negotiated rate.
29	**Medication therapy management services.** Amends § 256B.0625, subd. 13h. Makes the following changes related to coverage of medication therapy management services: • allows persons taking three or more prescriptions with one or more chronic conditions to be eligible (current law requires four or more prescriptions with two or more chronic conditions) • allows coverage of persons with a drug therapy problem that is identified by a pharmacist and approved by the commissioner • allows provision of the service in home settings,	House-only provision.	

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	without an order from the provider-directed care coordination team, and also expands the definition of home settings to include long-term care settings, group homes, and assisted living facilities		
30	**Transportation costs.** Amends § 256B.0625, subd. 17. Effective July 1, 2011, reduces nonemergency transportation rates, including special transportation, taxi, and other commercial carriers, by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.	Identical.	**Section 18 (256B.0625, subdivision 17)** reduces nonemergency transportation rates by 4.5 percent.
31	**Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Effective July 1, 2011, reduces ambulance service rates by 4.5 percent. Requires managed care and county-based purchasing plan payments to be reduced beginning January 1, 2012, to reflect this reduction.	Identical.	**Section 19 (256B.0625, subdivision 17a)** reduces ambulance services rates by 4.5 percent.
32	**Bus or taxicab transportation.** Amends § 256B.0625, subd. 18. Removes language providing that MA covers the "costs" of the most appropriate and cost-effective form of transportation.	Identical.	**Section 20 (256B.0625, subdivision 18)** removes the words "costs of" in terms of coverage for the most appropriate and cost effective form of transportation.
		Senate-only provision.	**Section 21 (256B.0625, subdivision 25)** requires the commissioner to implement a modernized electronic system for providers to request prior authorization. This section specifies what the system must include. The system must be completed by March 1, 2012, and all authorization requests after that date must be submitted electronically.
33	**Authorization with third-party liability.** Amends § 256B.0625, by adding subd. 25b. (a) Prohibits the commissioner from considering a request for authorization of a service when the recipient has third-party coverage, unless the	Identical.	**Section 22 (256B.0625, subdivision 25b)** requires that providers secure authorization or payment from third-party payers prior to requesting authorization for payment from Minnesota health care programs.

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	provider has made a good faith effort to obtain payment or authorization from the third-party. (b) States that a provider is not required to bill Medicare before requesting authorization from the commissioner, if the provider has reason to believe the service is not eligible for Medicare payment. (c) Provides that authorization is not required if a third-party has made payment equal to or greater than 60 percent of the maximum payment allowed under MA.		
34	**Augmentative and alternative communication systems.** Amends § 256B.0625, subd. 31a. Requires augmentative and alternative communication systems to be paid at the lower of: (1) the submitted charge; or (2) the manufacturer's suggested retail price minus 20 percent for providers that are manufacturers, or the manufacturer's invoice charge plus 20 percent for providers that are not manufacturers. (Under current law, payment is at the manufacturer's suggested retail price.)	Identical.	**Section 23 (256B.0625, subdivision 31a)** changes the payment methodology for augmentative and alternative communication systems in the Minnesota health care programs, as specified in this section.
35	**Payment for multiple services provided on the same day.** Amends § 256B.0625, by adding subd. 55. Requires the commissioner to allow payments for mental health or dental services, even if provided on the same day as other covered services furnished by the same provider.	House-only provision.	
36	**Medical care coordination.** Amends § 256B.0625, by adding subd. 56. (a) Provides MA coverage for in-reach community-based care coordination that is performed in a hospital emergency department as an eligible procedure under a state health care program or private insurance for a frequent user.	House-only provision.	

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	(b) Requires reimbursement to be made in 15-minute increments under Medicaid mental health social work reimbursement methodology and allowed for up to 60 days following discharge. Provides that frequent users receiving care coordination from a health care home are not eligible for reimbursement. Sets requirements for in-reach care coordinators. (c) Defines a frequent user. (d) Requires participating hospitals to make program utilization data available, upon the request of the commissioner. (e) Defines "in-reach community-based care coordination" as the practice of a community-based worker meeting specified criteria working with an organization's staff to transition an individual back into the individual's living environment. Provides that this coordination includes working with an individual during discharge and for up to a defined amount of time in the individual's living environment, reducing the individual's need for readmittance.		
37	**Payment for Part B Medicare crossover claims.** Amends § 256B.0625, by adding subd. 57. Effective January 1, 2012, limits MA payment for an enrollee's Medicare Part B cost-sharing to an amount, when combined with Medicare payments, that does not exceed the MA rate.	Identical.	**Section 26 (256B.0625, subdivision 57)** limits MA payment for Medicare crossover claims to the MA payment rate. This is effective for services provided on or after January 1, 2012.

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38	**Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, by adding subd. 58. Limits MA payment amounts for EPSDT screening to the payment rate established in rule (75th percentile of charges) and in effect on October 1, 2010 (this has the effect of eliminating annual adjustments to the rate).	Identical.	**Section 27 (256B.0625, subdivision 58)** freezes rates on payments to providers for child and teen check-up screenings.
39	**Services provided by advanced dental therapists and dental therapists.** Amends § 256B.0625, by adding subd. 59. Provides MA coverage for services provided by advanced dental therapists and dental therapists, when provided within their scope of practice.	House-only provision.	
40	**Payment for noncovered services.** Amends § 256B.0625, by adding subd. 60. Specifies the conditions under which a provider can seek payment from a recipient for services not eligible for payment under MA.	Technical difference only (capitalization); staff recommend Senate.	**Section 24 (256B.0625, subdivision 55)** allows a provider to seek payment from the recipient for services not eligible for payment under MA when the provider reviews and considers all available covered alternatives with the recipient, and obtains a signed acknowledgement from the recipient of the potential of the recipient's liability.
41	**Cost-sharing.** Amends § 256B.0631, subd. 1. Makes the following changes related to MA cost-sharing: • reinstates certain co-payments (these had been reduced or eliminated by the legislature) • requires a family deductible • establishes tiered copayments for nonpreventive visits	House-only provision.	
42	**Exceptions.** Amends § 256B.0631, subd. 2. Makes a conforming change related to cost-sharing changes.	House-only provision.	

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43	**Collection.** Amends § 256B.0631, subd. 3. Makes a conforming change related to cost-sharing changes.	House-only provision.	
44	**Reimbursement under other state health care programs.** Amends § 256B.0644. Allows an entity that operates both a Medicare certified comprehensive outpatient rehabilitation facility and a facility licensed to provide residential programs and services for persons with physical disabilities to limit the eligibility of new state health care program patients for specific categories of rehabilitative services, if state health care program patients make up more than 30 percent of the provider's patient population.	House-only provision.	
		Senate-only provision.	**Sections 28 to 30 (256B.0651, subdivision 1; 256B.0653, subdivision 2; and 256B.0653, subdivision 6)** eliminate physical therapy, occupational therapy, respiratory therapy, and language-speech pathology therapy from home care services and home health agency services.
45	**Definitions.** Amends § 256B.0751, subd. 1. Allows mental health professionals to be personal clinicians in a health care home.	House-only provision.	
46	**Development and implementation of standards.** Amends § 256B.0751, subd. 2. Modifies criteria for health care homes. Changes include adding references to mental health professionals, requiring coordination between social, public health and other services, and adjusting various measures for socioeconomic factors.	House-only provision.	

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47	**Requirements for clinicians certified as health care homes.** Amends § 256B.0751, subd. 3. Allows community mental health centers to be certified as health care homes. Makes conforming changes.	House-only provision.	
48	**Alternative models and waivers of requirements.** Amends § 256B.0751, subd. 4. A new paragraph (b) requires the commissioner of health, effective July 1, 2012, to certify FQHCs and FQHC look-alikes as health care homes, without requiring all health care home standards to be met. A new paragraph (c) allows the commissioner of health to waive health care home certification requirements if the applicant demonstrates that compliance will create a major financial hardship or is not feasible, and establishes an alternative method of meeting the objectives of the certification requirement.	House-only provision.	
49	**Coordination with local services.** Amends § 256B.0751, by adding subd. 8. Requires health care homes and counties to coordinate care and services for health care home enrollees with complex medical or socio-economic needs or a disability, who need or are eligible for waivered services, mental health services, or other local services.	House-only provision.	
50	**Patient choice of health care home.** Amends § 256B.0751, by adding subd. 9. Allows the commissioner, subject to federal approval, to require state health care program enrollees to select a health care home from which to receive primary care and care coordination services, as a condition of program enrollment. Requires the enrollee to be allowed to choose from among all qualified providers, if the provider is certified	House-only provision.	

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	as a health care home and agrees to accept the requirements for participation of the managed care plan, county-based purchasing plan, fee for service program, or demonstration project. Provides that reimbursement to FQHCs and FQHC look-alikes must be in compliance with federal law.		
51	**Engagement of patients and communities in health care home.** Amends § 256B.0751, by adding subd. 10. Requires health care homes to demonstrate that their patients, and the racial and ethnic communities of patients, participate in evaluating the health care home and recommending improvements and changes to the home's methods and procedures, in order to improve health, quality, and patient satisfaction. Requires the commissioner to consult with racial and ethnic communities to identify whether health care home requirements limit the effectiveness of health care home services.	House-only provision.	
52	**Waiver recipients.** Amends § 256B.0753, by adding subd. 4. Requires health care homes to receive the highest level of care coordination payment for providing services to enrollees receiving home and community-based waiver services.	House-only provision.	
53	**Primary care provider tiering.** Amends § 256B.0754, by adding subd. 3. Requires the commissioner to establish a tiering system for Minnesota health care program providers, that differentiates providers based on the quality and cost-effectiveness of care and incorporates provider peer grouping measures. Requires payment rates to be adjusted on an annual basis. Classifies health care homes, rural health clinics, and FQHCs as high-performing providers under this subdivision. Provides an effective date of one year from the public release of peer grouping measures, or upon federal approval, whichever is later.	House-only provision.	

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54	**Payment system.** Amends § 256B.0755, subd. 4. Requires the total cost of care benchmark for health care delivery system demonstration projects to be no greater than the capitation rate that would otherwise apply. Requires rate adjustments related to socioeconomic barriers and complexity.	House-only provision.	
55	**Coordination with local services.** Amends § 256B.0755, by adding subd. 8. Requires health care homes and counties to coordinate care and services for patients enrolled in a health care delivery system demonstration project with complex medical or socio-economic needs or a disability, who need or are eligible for waivered services, mental health services, or other local services.	House-only provision.	
56	**Rural demonstration projects.** Amends § 256B.0755, by adding subd. 8. Establishes requirements for health care delivery system projects serving rural areas. Requires consultation with local stakeholders, allows county public health or social services agencies or a county-based purchasing plan to establish a project, and requires the commissioner to approve only one project in rural areas where multiple projects are not possible.	House-only provision.	
57	**Patient choice of qualified provider.** Amends § 256B.0755, by adding subd. 9. Requires the commissioner to implement and approve health care delivery system demonstration projects in a manner that allows a patient to choose a primary care provider and health care home from among all qualified options. Requires the inclusion of essential community providers, if the ECP agrees to accept the requirements for participation in the demonstration project. Provides that reimbursement to FQHCs and FQHC look-alikes must be in compliance with federal law.	House-only provision.	

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Section	Article 5: Health Care		Article 5: Health Care
58	**Patient and community engagement.** Amends § 256B.0755, by adding subd. 10. Requires demonstration projects to demonstrate that consumers and communities to be served were consulted in project development. Also requires ongoing consultation.	House-only provision.	
59	**Care coordination system.** Amends § 256B.0755, by adding subd. 11. Requires the commissioner of human services, in consultation with the commissioner of health, to convene an advisory committee to advise the commissioner on establishing a system that will allow demonstration providers to effectively coordinate and deliver care. Requires the commissioner to contract with a vendor to establish and maintain the technology for the care coordination system. Requires planning, development, and establishment of the system to be funded through appropriations made for the purpose, and requires ongoing costs to be covered by payments from providers.	House-only provision.	
60	**Approval and implementation.** Amends § 256B.0755, by adding subd. 12. Requires the commissioner to approve delivery reform demonstration projects for MA and MinnesotaCare, to commence January 1, 2012. Allows approval of projects for fee-for-service and allows the commissioner to require managed care and county-based purchasing plans to contract with a demonstration project provider in the same manner as under fee-for-service.	House-only provision.	
61	**Hennepin and Ramsey counties pilot program.** Amends § 256B.0756. Requires this demonstration project to meet requirements that apply to delivery reform demonstration projects under section 256B.0755, subd. 8 to 11.	House-only provision. (Note: this section should be removed given House repeal of early MA expansion.) Senate repeals section 256B.0756.	See Repealer section. (Coincides with the repeal of the MA early expansion for adults without children.)

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Section	Article 5: Health Care		Article 5: Health Care
62	**Pregnancy care homes.** Adds § 256B.0758. **Subd. 1. Definitions.** Defines terms. **Subd. 2. Development and implementation of standards.** Requires the commissioners of human services and health to develop and implement certification standards for pregnancy care homes for state health care programs. **Subd. 3. Criteria for development of standards.** Requires a pregnancy care home to meet certain health care home standards, and also the standards specified in this subdivision. **Subd. 4. Certification process.** Allows certified providers to provide pregnancy care services through pregnancy care homes beginning July 1, 2012. Beginning July 1, 2014, requires all nonemergency pregnancy care services covered under state health care programs to be provided through pregnancy care homes. **Subd. 5. Payments to pregnancy care homes.** Requires the commissioner of human services, in coordination with the commissioner of health, to develop a payment system that provides a single per-person payment to cover all pregnancy services. Specifies other criteria for payments. Requires payments to be made beginning July 1, 2012, for services provided to pregnant women who are not high-risk, and requires payment beginning July 1, 2014, for both low-risk and high-risk pregnancies.	House-only provision.	

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63	**Care coordination for enrollees.** Adds § 256B.0758. **Subd. 1. Qualified enrollee.** Defines qualified enrollees as MA and MinnesotaCare enrollees. **Subd. 2. Selection of primary care provider.** Directs the commissioner to require qualified enrollees without a designated medical condition to select a primary care provider and agree to receive primary care services from that provider as a condition of program participation. **Subd. 3. Selection of health care home; care coordination.** Directs the commissioner to require qualified enrollees who have a medical condition designated by the commissioner to select a health care home, and agree to receive primary care and care coordination services through that provider as a condition of program participation. In order to receive payment from MA or MinnesotaCare for a non-emergency inpatient admission, requires hospitals to receive prior authorization from the enrollee's health care home. Provides an effective date of January 1, 2012, for MinnesotaCare enrollees not eligible for a federal match, and January 1, 2012, or upon federal approval, whichever is later, for MA enrollees and MinnesotaCare enrollees eligible for a federal match.	House-only provision.	
64	**Elective surgery.** Adds § 256B.0759. Requires the commissioner to prohibit payment, beginning January 1, 2012, for elective or nonemergency surgical procedures for which less invasive and less costly alternative treatment methods are available, if these alternative methods have not been evaluated and provided to the enrollee if appropriate. Requires managed	House-only provision.	

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	care plans to implement these prohibitions and reduces capitation rates to reflect cost-savings.		
65	**Private benefits to be used first.** Amends § 256B.37, subd. 5. Provides that coverage provided through the U.S. Department of Veterans Affairs is primary to MA coverage.	House-only provision.	
66	**County authority.** Amends § 256B.69, subd. 3a. Requires the commissioner to involve county boards when issuing an RFP for health care delivery demonstration projects. Allows the county board to decide a maximum number of participating plans under PMAP or a health care delivery demonstration project. Requires the county board or the commissioner to select one or more qualified plans. If agreement cannot be reached on the selection of plans or demonstration projects, requires the commissioner to resolve disputes by approving the recommendations of a mediation panel. Provides that this section also applies to MinnesotaCare.	House-only provision.	
67	**Limitation of choice.** Amends § 256B.69, subd. 4. Requires the commissioner to assign individuals who do not choose a managed care plan to the county-based purchasing plan, if any, in the county of residence of the individual.	Different intent: House requires commissioner to assign individuals who do not choose a managed care plan to the county-based purchasing plan in the county of residence, if a plan exists. Senate requires the commissioner to enroll the disabled into managed care plans unless the person opts out.	**Section 31 (256B.69, subdivision 4)** requires persons eligible for MA due to blindness or disability be enrolled in prepaid Medical Assistance Program (PMAP), unless the person elects to opt out. The opt-out does not apply to persons who are 65 or older or reside in Itasca County or another county where the commissioner conducts a section 1115 waiver pilot.
68	**Managed care contracts.** Amends § 256B.69, subd. 5a. Effective January 1, 2012, requires the commissioner to include as a performance target a reduction in a plan's rate subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue	Identical.	**Section 32 (256B.69, subdivision 5a**) includes, as part of the performance targets required to be met by managed care plans, a requirement that the plan reduces its hospitalization rate for subsequent hospitalizations within 30 days of the previous hospitalization by five percent from the previous calendar year's rate. This target is to be increased each year by five percent until the plan's subsequent hospitalization rate

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	until the plan's subsequent hospitalization rate is reduced by 25 percent.		is reduced by 25 percent.
69	**Medical education and research fund.** Amends § 256B.69, subd. 5c. Beginning in FY 2012, requires the commissioner to reduce the amount transferred from PMAP payments to the medical education research fund by $4,500,000.	House-only provision. (Senate eliminates the amount transferred from PMAP payments to the MERC fund over the specified $21,714,000 amount – see Senate section 5.)	
70	**Service delivery.** Amends § 256B.69, subd. 6. Requires a managed care or county-based purchasing plan to accept into its MA and MinnesotaCare networks any health care or social service provider that agrees to the terms applicable to similarly situated providers.	House-only provision.	
71	**Provider payment rates.** Amends § 256B.69, by adding subd. 30. Requires managed care and county-based purchasing plans to implement progressive payment withhold methodologies, based upon a provider's risk adjusted total annual cost of care, relative to other providers of the same type. Requires each plan to establish a benchmark percentile for the return of the withhold that allows it to adjust provider payments to reflect the reduction in capitation rates. Requires the commissioner to reduce capitation rates by 12 percent, for the contract year beginning January 1, 2012, and allows additional reductions in future years. Allows plans to reduce payments to providers. Requires plans to use the withhold methodology specified by this subdivision, unless the plan develops an alternative model consistent with the purposes of the subdivision.	House-only provision.	
72	**Initiatives to reduce incidence of low birth weight.** Amends § 256B.69, by adding subd. 30. Requires managed care and county-based purchasing plans to implement strategies to reduce the incidence of low-birth weight in geographic areas with a higher than average incidence of low birth weight.	House-only provision.	

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	Specifies criteria for initiatives and requires implementation by July 1, 2012. Requires the commissioner to evaluate the strategies.		
73	**Health education.** Amends § 256B.69, by adding subd. 31. Directs the commissioner to require managed care and county-based purchasing plans to provide health education, wellness training, and information about the availability and benefits of preventive services to all MA and MinnesotaCare enrollees, beginning January 1, 2012.	House-only provision.	
74	**Duties of commissioner of health.** Amends § 256B.692, subd. 2. Allows a county-based purchasing plan to satisfy its fiscal solvency requirements by obtaining written financial guarantees from participating counties.	House-only provision.	
75	**County proposals.** Amends § 256B.692, subd. 5. Eliminates the requirement that county boards submit preliminary proposals 15 months prior to the termination of health plan contracts to implement county-based purchasing.	House-only provision.	
76	**Dispute resolution.** Amends § 256B.692, subd. 7. In cases where the commissioner rejects a proposal for county-based purchasing, allows the county board to request a decision by a three-person mediation panel, and requires the commissioner to follow the decision of the panel.	House-only provision.	
77	**Patient choice of qualified provider.** Amends § 256B.692, by adding subd. 11. Effective January 1, 2012, requires county boards operating a county-based purchasing plan to ensure that each enrollee has the option of choosing a primary care provider or health care home from all qualified providers, who agrees to the terms, conditions, and payment rates offered by the plan to similarly situated providers. Requires FQHCs and FHQC look-alikes to be reimbursed as required under federal law.	House-only provision.	

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78	**Sole-source or single-plan managed care contract.** Amends § 256B.694. Requires the commissioner, at the request of a county or group of counties, to approve contracting on a single-plan basis to serve Minnesota health care program enrollees. (Under current law, the commissioner is required to consider requests to serve persons with a disability.)	House-only provision.	
		Senate-only provision.	**Section 33 (256B.695)** establishes the Healthy Minnesota Contribution Program for certain medical assistance enrollees. **Subdivision 1, paragraph (a)**, requires the commissioner, beginning January 1, 2012, to provide certain medical assistance enrollees with family income greater than 75 percent of the federal poverty guidelines (FPG) with a monthly defined contribution in order to purchase health coverage through a health plan in the private individual market. **Paragraph (b)** exempts these enrollees from the required enrollment in a managed care plan or a county-based purchasing plan. **Paragraph (c)** states that the medical assistance provisions related to covered services (section 256B.0625), and cost sharing (section 256B.031), do not apply to these enrollees. This paragraph also states that the covered services, cost sharing, and disenrollment for nonpayment of premiums, are, instead, provided by the terms of the health plan purchased by the enrollee. This paragraph also states that a health plan purchased by an enrollee shall be considered a prepaid health plan for purposes of compliant process and appeals

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			Paragraph (d) specifies that unless otherwise provided in this section, all medical assistance requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply. States that retroactive coverage still applies to these enrollees. **Subdivision 2** allows enrollees to use up to the monthly defined contribution as determined under **subdivision 3** to pay premiums for coverage under a health plan. **Subdivision 3, paragraph (a)**, requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per person defined contribution is a function of age and income. This paragraph specifies that the monthly per person base contribution ranges from $122.79 for persons under the age of 21 to $357.19 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 110 to 80 percent, to obtain the monthly per person defined contribution amount. **Paragraph (b)** requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through MCHA. **Paragraph (c)** states that notwithstanding paragraphs (a) and (b), the monthly defined contribution shall not exceed 90 percent of the monthly premium for the health plan purchased by the enrollee, and shall be reduced by five percent if the health plan the enrollee chooses to purchase

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			does not include coverage for mental health and chemical dependency treatment services. **Subdivision 4** requires the commissioner to administer the defined contributions by calculating and processing defined contributions for enrollees and paying the defined contribution to the health plan companies or MCHA, as applicable. **Subdivision 5** requires the Commissioner of Human Services, in consultation with the Commissioner of Commerce, to develop an efficient and cost-effective method to refer eligible enrollees to professional insurance agent associations. **Subdivision 6** states that beginning January 1, 2012, medical assistance enrollees who are eligible under this section, and who are denied coverage in the individual market are eligible for coverage through MCHA and may enroll in MCHA in accordance with chapter 62E. This paragraph also states that any difference between the revenue and covered losses to MCHA related to the implementation of this section shall be paid to MCHA from the health care access fund. **Subdivision 7** requires the commissioner to seek all federal approvals and waivers necessary to implement this section.
79	**Critical access dental providers.** Amends § 256B.76, subd. 4. Eliminates critical access dental provider eligibility for a dental clinic "associated with an oral health or dental education program" operated by the University of Minnesota or MNSCU, and requires a dental clinic to be owned and operated	Identical on critical access dental provider eligibility. House prohibits rulemaking; Senate does not.	**Section 34 (256B.76, subdivision 4)** relates to critical access dental (CAD) providers to clarify that only clinics that are University of Minnesota or Minnesota State Colleges and Universities owned and operated may be designated as CAD providers.

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	by these entities in order to qualify as a critical access dental provider. Prohibits the commissioner from adopting rules related to critical access dental providers.		
80	**Patient-centered decision-making.** Adds § 256B.7671. (a) Effective January 1, 2012, requires the commissioner to require active participation in a patient-centered decision-making process before authorization is approved or payment made for specific procedures. (b) Requires the list of procedures to be published in the State Register and reviewed at least every two years. (c) Requires health care providers to certify that a patient has participated in a patient-centered decision-making process, and requires the format and process to be developed by the Health Services Policy Committee. (d) Defines "patient-centered decision-making process." (e) States that this section does not apply in emergency situations.	House-only provision.	
81	**Complementary and alternative medicine demonstration project.** Adds § 256B.771. Requires the commissioner of human services, in consultation with the commissioner of health, to contract with a Minnesota-based academic and research institution specializing in complementary and alternative medicine to implement a demonstration project to improve the care provided to MA enrollees with neck and back problems. The project must be conducted with FQHCs and FQHC look-alikes. Requires the project to be implemented beginning July 1, 2011, or upon federal approval, whichever is later.	House-only provision.	

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82	**Waiver application and process.** Adds § 256B.841. **Subd. 1. Intent.** Provides an intent statement. **Subd. 2. Waiver application.** Requires the commissioner to apply for a waiver and any necessary state plan amendments that provides program flexibility and under which Minnesota will operate its MA program. Requires the commissioner to provide the relevant legislative committees with the waiver application and related materials. If the waiver application is approved, requires the commissioner to notify legislative chairs, allow review by legislative committees, and not implement the waiver until ten legislative days have passed following notification. **Subd. 3. Rulemaking; legislative proposals.** Upon acceptance of the waiver, requires the commissioner to adopt rules and to propose any legislative changes needed to implement the waiver. **Subd. 4. Joint commission on waiver implementation.** Requires the governor to establish a joint commission on waiver implementation. Specifies membership and duties.	Similar. Identical. House specifies a waiver application date; Senate does not. House refers to "other provisions of federal law"; Senate to the ACA. Identical. Identical.	**Section 35 (256B.841) Waiver Application and Process** **Subdivision 1** provides an intent statement. **Subdivision 2** the commissioner to apply for a waiver and any necessary state plan amendments that provides program flexibility and under which Minnesota will operate its MA program. Requires the commissioner to provide the relevant legislative committees with the waiver application and related materials. If the waiver application is approved, requires the commissioner to notify legislative chairs, allow review by legislative committees, and not implement the waiver until ten legislative days have passed following notification. **Subdivision 3** upon acceptance of the waiver, requires the commissioner to adopt rules and to propose any legislative changes needed to implement the waiver. **Subdivision 4** requires the Governor to establish a joint commission on waiver implementation. Specifies membership and duties.
83	**Principles and goals for medical assistance reform.** Adds § 256B.842. **Subd. 1. Goals for reform.** Requires the commissioner to ensure that the reformed MA program is a person-centered, financially sustainable, and cost-effective program.	Identical.	**Section 36 (256B.842) Principles and Goals for Medical Assistance Reform** **Subdivision 1** requires the commissioner to ensure that the reformed MA program is a person-centered, financially sustainable, and cost-effective program.

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	Subd. 2. Reformed medical assistance criteria. Establishes criteria for the reformed program. **Subd. 3. Annual report.** Requires the commissioner to report annually to the governor and the legislature on the status of the administration and implementation of the waiver.		**Subdivision 2** establishes criteria for the reformed program. **Subdivision 3** requires the commissioner to report annually to the Governor and the Legislature on the status of the administration and implementation of the waiver.
84	**Waiver application requirements.** Adds § 256B.843. **Subd. 1. Requirements for waiver request.** Requires the commissioner to seek federal approval to enter into a five-year agreement with the federal government under section 1115a to waive specific provisions of Medicaid law, including but not limited to statewideness, comparability of services, and freedom of choice of providers. Also requires the commissioner to seek a waiver of Medicaid law provisions, in order to expand cost-sharing, establish health savings or power accounts, provide enrollees with a choice of appropriate private sector coverage, consolidate waivered services, and implement other specified initiatives. **Subd. 2. Agency coordination.** Requires the commissioner to establish an intraagency assessment and coordination unit.	Identical, except for technical difference in subd. 2 (staff recommend Senate).	**Section 37 (256B.843) Waiver Application Requirements** **Subdivision 1** requires the commissioner to seek federal approval to enter into a five-year agreement with the federal government under section 1115a to waive specific provisions of Medicaid law, including but not limited to statewideness, comparability of services, and freedom of choice of providers. Also requires the commissioner to seek a waiver of Medicaid law provisions, in order to expand cost-sharing, establish health savings or power accounts, provide enrollees with a choice of appropriate private sector coverage, consolidate waivered services, and implement other specified initiatives. **Subdivision 2** requires the commissioner to establish an intra-agency assessment and coordination unit.
85	**General assistance medical care; eligibility.** Amends § 256D.03, subd. 3. Reinstates the modified GAMC program (which would delivery care through coordinated care delivery systems (CCDS)), effective January 1, 2012. Requires outpatient prescription drug coverage to be provided through CCDSs.	House-only provision.	

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86	**Coordinated care delivery systems.** Amends § 256D.031, subd. 6. Makes changes to CCDS service delivery. Requires outpatient prescription drug coverage to be provided through CCDSs. Allows county-based purchasing plans to establish CCDSs. Requires hospitals and plans operating a CCDS to give preference to health care homes when contracting with providers, and to contract with FQHCs and FQHC look-alikes, and essential community providers, that accept contract terms.	Similar general intent, with following differences: 1. House reinstates CCDSs January 1, 2012; Senate July 1, 2011. 2. House allows county-based purchasing plans to establish CCDSs; Senate does not. 3. House and Senate CCDS enrollment dates differ (due to different effective dates). 4. Senate language on enrollee assignment includes a reference to paragraph (k); House does not. 5. House requires a CCDS to give preference to health care homes when contracting and requires contracting with FQHCs, FQHC look-alikes, and essential community providers; Senate does not. 6. House requires the commissioner to negotiate enrollment thresholds and financial liability protections; Senate allows this. 7. Senate exempts outpatient prescription drug coverage from the CCDS payments; House does not.	**Section 38 (256D.031, subdivision 6)** reinstates the GMAC program and the coordinated care delivery systems effective July 1, 2011, and permits a hospital or group of hospitals to contract with the commissioner to deliver services if the hospital or group of hospitals agree to satisfy the requirements.
87	**Payments; rate setting for the coordinated care delivery system.** Amends § 256D.031, subd. 7. Reinstates CCDS payment language. Requires payments to hospitals and plans operating a CCDS to be based upon enrollment thresholds negotiated with the commissioner.	Similar general intent, with following differences: 1. House and Senate have different CCDS payment dates (due to different effective dates). 2. House allocates CCDS payments on basis of enrollment thresholds negotiated with the commissioner; Senate on the pro-rata share of CY 2009 payments to hospitals for GAMC services, and retains language increasing payments to specified hospitals.	**Section 39 (256D.031, subdivision 7)** establishes the payment rates for the coordinated care delivery systems.

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		Senate-only provision. (House does not reinstate the prescription drug pool).	**Section 40 (256D.031, subdivision 9)** establishes the prescription drug pool effective July 1, 2011, for the GAMC program.
88	**Assistance for veterans.** Amends § 256D.031, subd. 10. Makes a conforming change related to county-based purchasing plans being allowed to operated CCDSs.	House-only provision.	
89	**Gross individual or gross family income.** Amends § 256L.01, subd. 4a. Makes conforming changes to the reduction in the MinnesotaCare eligibility period from 12 to six months.	House-only provision.	
90	**Financial management.** Amends § 256L.02, subd. 3. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.	House-only provision.	
91	**Financial management.** Amends § 256L.02, subd. 3. Makes a conforming change related to elimination of the Legislative Commission on Health Care Access.	House-only provision.	
92	**Inpatient hospital services.** Amends § 256L.03, subd. 3. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.	House-only provision.	
93	**Cost-sharing.** Amends § 256L.03, subd. 5. Requires MinnesotaCare enrollees to pay a family deductible. Effective January 1, 2012, establishes tiered copayments for nonpreventive visits. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.	House-only provision.	

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94	**Healthy Minnesota contribution program.** Adds § 256L.031. **Subd. 1. Defined contribution to enrollees.** (a) Requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are adults without children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan. Requires the commissioner, beginning January 1, 2012, or upon federal approval, whichever is later, to provide MinnesotaCare enrollees who are families and children, with gross family income equal to or greater than 133 percent of FPG, with a monthly defined contribution to purchase a health plan. (b) Exempts these enrollees from MinnesotaCare premiums, and required enrollment in a managed care or county-based purchasing plan. (c) Provides that the provisions related to MinnesotaCare covered services and cost-sharing (§ 256L.03), the effective date of coverage (§ 256L.05, subd. 3), and provider payment rates (§ 256L.11) do not apply to these enrollees. Covered services, cost-sharing, disenrollment for nonpayment of premium, enrollee appeal rights and complaint procedures, and the effective date of coverage are as provided by the terms of the health plan purchased by the enrollee.	Similar, with differences as noted. House income floor for participation is 133 percent of FPG; Senate 75 percent of FPG. House includes a reference to federal approval for families with children enrollment. Also technical differences in paragraph formatting.	**Section 41 (256L.031)** establishes the Healthy Minnesota Contribution Program. **Subdivision 1, paragraph (a)**, requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are adults without children with gross family income equal to or greater than 75 percent of FPG with a monthly defined contribution in order to purchase health coverage through a health plan in the private individual market. **Paragraph (b)** requires the commissioner, beginning January 1, 2012, to provide MinnesotaCare enrollees who are families with children, with gross family income equal to or greater than 133 percent of FPG with a monthly defined contribution in order to purchase health coverage through a health plan in the private individual market. **Paragraph (c)** exempts these MinnesotaCare enrollees from MinnesotaCare premiums and the required enrollment in a managed care plan or a county-based purchasing plan.

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	(d) States that all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply, unless otherwise provided in this section.		**Paragraph (d)** states that the MinnesotaCare provisions related to covered services (Minnesota Statutes, section 256L.03), cost sharing (section 256L.03, subdivision 5), the effective date of coverage (section 256L.05, subdivision 3), and provider payments (section 256L.11) do not apply to these enrollees. This paragraph also states that the covered services, cost sharing, disenrollment for nonpayment of premiums, appeal rights and complaint procedures, and the effective date of coverage for enrollees are, instead, provided by the terms of the health plan purchased by the enrollee. **Paragraph (e)** specifies that unless otherwise provided in this section, all MinnesotaCare requirements related to eligibility, income and asset methodology, income reporting, and program administration continue to apply.
	Subd. 2. Use of defined contribution. Allows enrollees to use up to the monthly defined contribution only to pay premiums for coverage under a health plan.	Identical.	**Subdivision 2** allows enrollees to use up to the monthly defined contribution as determined under **subdivision 3** to pay premiums for coverage under a health plan.
	Subd. 3. Determination of defined contribution amount. (a) Requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per-person defined contribution is a function of age and income. Specifies the monthly per-person base contribution for age groups, ranging from $122.79 for persons under age 21 to $357.19 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 150 to 80	Difference in the sliding scale, tied to the different income limits. Difference in the defined contribution percentage for the lowest income group.	**Subdivision 3, paragraph (a)**, requires the commissioner to determine the defined contribution amount using a sliding scale, under which the per person defined contribution is a function of age and income. This paragraph specifies that the monthly per person base contribution ranges from $122.79 for persons under the age of 21 to $357.19 for persons age 60 and over. The base contribution is multiplied by a percentage inversely related to income, ranging from 110 to 80 percent, to

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	percent, to obtain the monthly per-person defined contribution amount.		obtain the monthly per person defined contribution amount.
	(b) Requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through the Minnesota Comprehensive Health Association (MCHA).		**Paragraph (b)** requires the defined contribution amount calculated under paragraph (a) to be increased by 20 percent for enrollees who are denied coverage in the private individual market and who purchase coverage through MCHA.
	(c) Limits the monthly defined contribution to 90 percent of the maximum monthly premium for the health plan purchased by the enrollee. Reduces the monthly defined contribution amount by five percent if the enrollee purchases coverage that does not include mental health services and chemical dependency treatment services.		**Paragraph (c)** states that notwithstanding paragraphs (a) and (b), the monthly defined contribution shall not exceed 90 percent of the monthly premium for the health plan purchased by the enrollee, and shall be reduced by five percent if the health plan the enrollee chooses to purchase does not include coverage for mental health and chemical dependency treatment services.
	Subd. 4. Administration by commissioner. Requires the commissioner to administer the defined contributions, by calculating and processing defined contributions for enrollees and paying the defined contribution to health plan companies or MCHA, as applicable.	Identical.	**Subdivision 4** requires the commissioner to administer the defined contributions by calculating and processing defined contributions for enrollees and paying the defined contribution to the health plan companies or MCHA, as applicable.
	Subd. 5. Assistance to enrollees. Requires the commissioner of human services, in consultation with the commissioner of commerce, to develop an efficient and cost-effective method to refer applicants to professional insurance agent associations.	Identical.	**Subdivision 5** requires the Commissioner of Human Services, in consultation with the Commissioner of Commerce, to develop an efficient and cost-effective method to refer eligible enrollees to professional insurance agent associations.

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	Subd. 6. MCHA. Beginning January 1, 2012, makes MinnesotaCare enrollees who are denied coverage under an individual health plan eligible for coverage under MCHA. Requires incremental costs to MCHA resulting from implementation of this act to be paid from the health care access fund.	Identical.	**Subdivision 6** states that beginning January 1, 2012, MinnesotaCare enrollees who are eligible under this section, and who are denied coverage in the individual market are eligible for coverage through MCHA and may enroll in MCHA in accordance with chapter 62E. This paragraph also states that any difference between the revenue and covered losses to MCHA related to the implementation of this section shall be paid to MCHA from the health care access fund.
	Subd. 7. Federal approval. Requires the commissioner to seek all federal approvals and waivers necessary to implement coverage for enrollees eligible as families and children, with gross family incomes equal to or greater than 133 percent of FPG, while continuing to receive federal funds.	House specifies that a waiver is to be requested for participation by families and children; Senate waiver language is not as specific.	**Subdivision 7** requires the commissioner to seek all federal approvals and waivers necessary to implement coverage for enrollees eligible as families and children in order to continue to receive federal funds.
95	**Families with children.** Amends § 256L.04, subd. 1. Reduces the MinnesotaCare income limit for adults in families with children from 275 percent to 200 percent of the federal poverty guidelines. This reduction in the income limit is effective January 1, 2012, or upon federal approval, whichever is later, and expires June 30, 2013. Also eliminates an exemption from the program income limit for certain children who transition from MA to MinnesotaCare (other provisions related to this transition group are repealed in this article; federal approval for this transition has not yet been obtained). The elimination of the exemption from the income limit is effective retroactively to October 1, 2008.	House-only provision.	
96	**Single adults and households with no children.** Amends § 256L.04, subd. 7. Reduces the MinnesotaCare income limit for adults without children from 250 percent to 200 percent of	Both House and Senate eliminate MinnesotaCare eligibility for certain adults without children, but with different effective dates – Senate 7/1/11; House 1/1/12.	**Section 42 (256L.04, subdivision 7)** eliminates MinnesotaCare eligibility for single adults without children with income less than or equal to 75 percent of FPG.

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	the federal poverty guidelines. This provision is effective January 1, 2012, and expires June 30, 2013. Also eliminates eligibility for adults without children with incomes less than or equal to 75 percent of FPG, effective January 1, 2012.	House also reduces MinnesotaCare eligibility for adults without children from 250 percent to 200 percent of FPG, for an 18-month period; Senate does not.	
97	**Commissioner's duties.** Amends § 256L.05, subd. 2. Reinstates language repealed in a previous session that requires the commissioner to verify both earned and unearned income for MinnesotaCare enrollees, and verify eligibility for employer-subsidized insurance.	House-only provision.	
98	**Renewal of eligibility.** Amends § 256L.05, subd. 3a. Requires MinnesotaCare eligibility to be renewed every six months. (Under current law, eligibility must be renewed every 12 months.)	House-only provision.	
99	**Availability of private insurance.** Amends § 256L.05, subd. 5. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.	House-only provision.	
100	**Referral of veterans.** Amends § 256L.05, by adding subd. 6. Requires the commissioner to ensure that all MinnesotaCare applicants with incomes less than 133 percent of FPG, who identify themselves as veterans, are referred to a county veterans service officer for assistance in applying to the U.S. Department of Veterans Affairs for any VA benefits for which they are eligible.	Identical.	**Section 43 (256L.05, subdivision 6)** states that the commissioner is required to ensure that all MinnesotaCare applicants with gross family incomes less than 133 percent of FPG who identify themselves as a veteran are referred to a county veteran's service office for assistance in applying to the U.S. Department of Veterans Affairs for any VA benefits for which they are eligible.
101	**General requirements.** Amends § 256L.07, subd. 1. Reinstates in law the $50,000 income limit for parents under MinnesotaCare (the increase to $57,500 has not yet been approved by the federal government). Also makes conforming	House-only provision.	

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	changes related to the establishment of a six-month renewal period, and the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.		
102	**General requirements.** Amends § 256L.07, subd. 1. Makes a conforming change related to the elimination of MinnesotaCare eligibility for adults with incomes over 200 percent of FPG.	House-only provision.	
103	**Eligibility as Minnesota resident.** Amends § 256L.09, subd. 4. Requires MinnesotaCare enrollees to maintain a residence at a verified address other than a place of public accommodation, unless the place of public accommodation is the person's primary or only residence.	House-only provision.	
104	**Critical access dental providers.** Amends § 256L.11, subd. 7. Reduces MinnesotaCare payments to critical access dental providers from 50 percent to 30 percent above the regular payment rate, effective July 1, 2011.	Identical.	**Section 44 (256L.11, subdivision 7)** reduces the CAD add-on payment for MinnesotaCare from 50 percent to 30 percent, which is in line with the CAD add-on payment for MA.
105	**Rate setting; performance withholds.** Amends § 256L.12, subd. 9. Effective January 1, 2012, requires the commissioner to include as a performance target under MinnesotaCare a reduction in a plan's rate of subsequent hospitalizations, within 30 days of a previous hospitalization, by 5 percent from the rate for the previous calendar year. Requires withholds to be returned between July 1 and July 31 of the following year, if the target reduction rate is achieved. Requires this performance withhold to continue until the plan's subsequent hospitalization rate is reduced by 25 percent.	Identical.	**Section 45 (256L.12, subdivision 9)** includes, as part of the performance targets required to be met by managed care plans, a requirement that the plan reduces its hospitalization rate for subsequent hospitalizations within 30 days of the previous hospitalization by five percent from the previous calendar year's rate. This target is to be increased each year by five percent until the plan's subsequent hospitalization rate is reduced by 25 percent.
106	**Payment options.** Amends § 256L.15, subd. 1a. Requires the commissioner to include information about MinnesotaCare premium payment options on each premium notice.	House-only provision.	

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107	**Administrative costs.** Amends Laws 2008, chapter 63, article 18, section 3, subd. 5. Reduces the aggregate administrative cost limit for managed care and county-based purchasing plans from 6.6 to 6.1 percent of total contract payments.	House reduces the administrative cost limit to 6.1 percent; Senate to 5.3 percent.	**Section 46** reduces aggregate administrative costs paid to managed care and county-based purchasing plans from 6.6 to 5.3 percent of the total contract payment.
108	**Health care access fund transfer; GAMC grants.** Amends Laws 2010, First Sp. Session chapter 1, article 25, section 3, subd. 6. Reduces transfers from the health care access fund to the general fund related to early MA expansion, for fiscal years 2010 and 2011. Also reduces GAMC funding for FY 2011.	House and Senate have different transfer amounts. House reduces GAMC funding for FY 2011; Senate does not.	**Section 47** adjusts funding that corresponds with eliminating MA early expansion and reinstating the GAMC program.
109	**Commissioner's actions; repeal of early MA expansion.** Effective January 1, 2012, requires the commissioner of human services to suspend implementation and administration of early MA expansion for adult without children, and to refer these individuals to the reinstated GAMC program.	House-only provision.	
110	**GAMC program; provisions revived.** Effective January 1, 2012, revives selected provisions of the modified GAMC program that had been repealed with implementation of early MA expansion.	Similar intent (staff need to reconcile differences). Senate language should not be contingent on global waiver approval, but should be effective July 1, 2011.	**Section 52** revives language that established a new GAMC program based on coordinated care delivery systems. (These sections were repealed when MA early expansion was implemented.)
111	**Plan to coordinate care for children with high-cost mental health conditions.** Requires the commissioner of human services to submit to the legislature, by December 15, 2011, a plan to provide care coordination to MA and MinnesotaCare enrollees who are children with high-cost mental health conditions.	House-only provision.	
112	**Data on claims and utilization.** Requires the commissioner of human services to develop and provide to the legislature, by December 15, 2011, a methodology and draft legislation necessary to allow the release, upon request, of summary data on claims and utilization for state health care programs to	House-only provision.	

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	research institutions, to conduct analyses of health care outcomes and treatment effectiveness.		
113	**Reduction of state mandated reports.** (a) Requires the commissioner of management and budget to convene a report reduction working group. Requires the commissioner and the working group to develop a plan for report reduction. (b) Requires the commissioners of health, human services, and commerce to reduce, eliminate, or consolidate state-mandated reports according to the plan. Specifies other duties for the commissioners related to report reduction. (c) Requires the commissioner of management and budget, by January 15, 2012, to report to legislative chairs and ranking minority members on the activities and results of the report reduction project.	House-only provision.	
114	**Competitive bidding pilot.** Requires the commissioner of human services, for managed care contracts effective January 1, 2012, to establish a competitive price bidding pilot for nonelderly, nondisabled adults and children in MA and MinnesotaCare in the seven-county metropolitan area. Requires a minimum of two managed care organizations to serve the metropolitan area. Provides that the pilot expires after two full calendar years, on December 31, 2013. Requires the commissioner to evaluate the pilot to determine cost-effectiveness and impacts on access to providers. Also requires the commissioner to consult with other states and incorporate best practices, and to consult with stakeholders.	House requires commissioner to consult with other states; Senate does not. Otherwise identical.	**Section 48** requires the Commissioner of Human Services to establish a competitive bidding process to select managed care organizations to deliver services under MA and MinnesotaCare for nonelderly, nondisabled adults, and children. The pilot must allow a minimum of two managed care organizations to serve the metropolitan area. The pilot expires December 31, 2013, and an evaluation of the pilot is required to determine the cost-effectiveness and impacts to provider access.

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115	**Request for proposal; provider billing patterns.** Requires the commissioner of human services to issue a request for proposal to identify abnormal provider billing patterns. Requires the commissioner to enter into a contract by October 1, 2011.	House-only provision.	
116	**Health services policy committee studies.** (a) Requires the commissioner of human services, through the health services policy committee, to develop a process to limit payment to health professionals for services for which they are not trained to deliver in a high-quality manner. Requires the commissioner to report to the legislature by January 15, 2012. (b) Requires the commissioner of human services, through the health services policy committee, to study the effectiveness of new strategies for wound care treatment, and report to the legislature by December 15, 2011.	House-only provision.	
117	**Specialized maintenance therapy.** Requires the commissioner of human services to evaluate whether providing MA coverage for specialized maintenance therapy will reduce rates of hospitalization for enrollees with serious and persistent mental illness. Requires a report to the legislature by December 15, 2011.	House-only provision.	
118	**Coverage for lower-income MinnesotaCare enrollees.** Requires the commissioner of human services to develop and present to the legislature, by December 15, 2011, a plan to redesign service delivery for MinnesotaCare enrollees who are adults without children or families and children, with incomes less than 133 percent of FPG. Specifies plan criteria and requires the commissioner to consider innovative methods of service delivery, including but not limited to increasing the use and choice of private health plan coverage and encouraging the use of community clinics as health care homes.	House-only provision.	

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119	**Direction to commissioner; federal waivers.** (a) Requires the commissioner of human services to apply to the Centers for Medicare and Medicaid Services, by July 1, 2011, for federal waivers to cover: (1) MinnesotaCare families and children; and (2) MinnesotaCare parents, guardians and caretakers, under the Healthy Minnesota Contribution Program. Requires the commissioner to report to the relevant legislative committees whether or not the waiver application is accepted, within ten working days of the decision. Provides an immediate effective date. (b) Requires the commissioner of human services to apply to CMS for a demonstration waiver and any other necessary waivers and amendments that would provide the state with medical assistance program flexibility in exchange for federal budget certainty. Requires the commissioner to seek federal approval to enter into an agreement with CMS under which Minnesota would accept an aggregate annual allotment for MA, trended forward and with protections to cover medical inflation and projected caseload growth, and receive federal waivers of specified medical assistance program requirements. Provides an immediate effective date.	Paragraph (a) is similar; Senate also refers to children and families with children who are eligible for MA. Paragraph (b) is House-only provision, related to the global waiver.	**Section 49** requires the Commissioner of Human Services to apply for a federal waiver in order to include in the Healthy Minnesota Contribution Program families with children and, in the alternative, the parents of families with children who may be eligible.
120	**Transparency and quality reporting for public health care programs.** Requires the commissioner, when negotiating with vendors to provide managed care services, to require use of an advanced request for information tool, to provide DHS with an evidence-based assessment of the cost control, quality, and information transparency of the vendor.	House-only provision.	
121	**Risk corridors.** Requires the commissioner, for services provided on or after January 1, 2012, to establish risk corridors for each managed care and county-based purchasing plan, that	House-only provision.	

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	requires a portion of any net underwriting gain above a threshold to be repaid to the commissioner, and a portion of any net underwriting loss below a threshold to be paid by the commissioner. Provides that this section expires January 1, 2014.		
		Senate-only provision.	**Section 50** requires the Commissioner of Human Services to issue a request for proposals to prevent and detect Medicaid fraud. The Commissioner shall select a vendor by September 1, 2011.
		Senate-only provision.	**Section 51** prohibits state funds to be expended in the planning or implementation of the Patient Protection and Affordable Care Act, and no provisions of the act may be implemented until the constitutionality of the act has been affirmed by the United States Supreme Court. This section is effective the day following final enactment.
122	**Repealer.** (a) Repeals § 62J.07, subds. 1, 2, and 3 (Legislative Commission on Health Care Access). (b) Repeals an exemption for low-income children from the MinnesotaCare employer-subsidized insurance insurance barrier (see § 256L.07 subd. 2; this provision has not yet been approved by the federal government). (c) Repeals an exemption for low-income children from the Minnesota four-month uninsured requirement (see § 256L.07, subd. 3; this provision has not yet been approved by the federal government). (d) Repeals an exemption for low-income children from MinnesotaCare premiums (see § 256L.15, subd. 2; this	House-only repealers paragraphs (a) through (u). Senate-only repealers: sections 256B.0625, subd. 8e; 256B.0653, subd. 5; 256B.0756; 256D.031, subds. 5 and 8; 256B.055; and Laws 2010, First Special Session chapter 1, article 16, section 6, subd. 3; and section 7, subd. 4.	**Section 53** repeals: **Paragraph (a)**, sections 256B.0625, subdivision 8e (Chiropractic services); 256B.0653, subdivision 5 (Home care therapies); 256B.0756 (Hennepin and Ramsey Counties Pilot Program); and 256D.031, subdivisions 5 (Payment rates and contract modification; April 1, 2010, to May 31, 2010) and 8 (Temporary uncompensated care pool). **Paragraph (b)**, section 256B.055 (MA Eligibility Categories). Effective October 1, 2011. **Paragraph (c)**, Laws 2010, First Special Session chapter 1, article 16, sections 6, subdivision 3 (Asset limitations for individuals and families); and 7, subdivision 4 (Income). Effective October 1, 2011.

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	provision has not yet been approved by the federal government). (e) Repeals § 256L.07, subd. 7 (exemption of certain children transitioned from MA from MinnesotaCare insurance barriers) retroactively from October 1, 2008 (this provision has not yet been approved by the federal government). (f) Repeals an exemption for certain children transitioned from MA from MinnesotaCare income limits (see § 256L.04, subd. 1) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government). (g) Repeals a provision allowing children with incomes over 275 percent of FPG to remain on the program (see § 256L.04, subd. 1b) retroactively from January 1, 2009 (this provision has not yet been approved by the federal government). (h) Repeals a provision requiring a streamlined application and enrollment process for MA and MinnesotaCare enrollees (see § 256L.05, subd. 1c) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government). (i) Repeals a provision providing automatic MinnesotaCare eligibility for certain children from foster care and juvenile correctional facilities (see § 256L.07, subd. 8) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government). (j) Repeals a conforming change related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.04, subd. 7a). (k) Repeals language establishing the effective date of		

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	coverage for children from foster care and juvenile correctional facilities (see § 256L.05, subd. 3). (l) Repeals a provision that provides continued eligibility under MinnesotaCare for children who fail to submit renewal information in a timely manner (see § 256L.05, subd 3a) retroactively from July 1, 2009 (this provision has not yet been approved by the federal government). (m) Repeals language related to a provision allowing children with incomes over 275 percent of FPG to remain on MinnesotaCare, that is repealed elsewhere in this section (see § 256L.07, subd. 1; this provision has not yet been approved by the federal government). (n) Repeals an exemption for low-income children from the MinnesotaCare employer-subsidized insurance insurance barrier (see § 256L.07, subd. 2; this provision has not yet been approved by the federal government). (o) Repeals an exemption for low-income children from the MinnesotaCare four-month uninsured requirement (see § 256L.07, subd. 3; this provision has not yet been approved by the federal government). (p) Repeals an exemption for low-income children from MinnesotaCare premiums (see § 256L.15, subd. 2; this provision has not yet been approved by the federal government). (q) Repeals a provision exempting low-income children from MinnesotaCare premiums (see § 256L.15; this provision has not yet been approved by the federal government). (r) Repeals a provision requiring the commissioner of human services to request approval from the federal government to		

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	eliminate the add-back of depreciation when determining income eligibility under MinnesotaCare for self-employed farmers (uncodified section; this request has not yet been approved by the federal government). (s) Repeals § 256B.057, subdivision 2c (extended MA coverage for certain children; this provision has not yet been approved by the federal government). (t) Repeals provisions providing MinnesotaCare enrollees with a renewal rolling month and a premium grace month (these provisions have not yet been approved by the federal government).		
123	**Repealer; MA early expansion.** Repeals the MA early expansion for adults without children with incomes not exceeding 75 percent of FPG, effective January 1, 2012.	Different effective dates – House: January 1, 2012; Senate: October 1, 2011.	See Repealer **section 53, paragraphs (b) and (c)**.