Bill Summary Comparison of Health and Human Services

Senate File UEH1233-1
Article 6: Health Care

House File 1233, 3rd Engrossment
Article 6: Health Care

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1	**(245.03, subd. 1)** authorizes the Commissioner of Human Services to appoint up to two deputy commissioners.	Senate-only provision	
		House-only provision	**Section 1. Hospital surcharge.** Amends § 256.9657, subd. 2. Effective July 1, 2013, through June 30, 2017, increases the surcharge for nongovernment-owned hospitals to 2.68 percent of net patient revenues, excluding Medicare revenues. Provides that the surcharge reverts to the current rate of 1.56 percent, beginning July 1, 2017.
2	**(256.9657, subd. 3)** increases the surcharge on health maintenance organizations by .88 percent to a total of 1.48 percent effective July 1, 2013, until June 30, 2015.	Senate-only provision	
		House-only provision	**Section 2. Federal requirements.** Amends § 256.9685, subd. 2. Allows the commissioner to retrospectively rates and payments to avoid reduced federal financial participation resulting from rates and payments in excess of the Medicare upper payment limit. Also specifies the rate reduction procedure for the commissioner to follow if rates and payments are determined to be in excess of the upper payment limit for the nongovernmental-owned limit category.
3	**(256.969, subd. 3a)** increases the fee for service payment rate for inpatient hospital services by 1.4 percent beginning January 1, 2015.	Both bills increase hospital payment rates. The House increases payment rates by 30 percent for the period July 1, 2013, through June 30, 2017, and specifies the distribution of the increase across different groups of hospitals. The Senate provides a 1.4 percent fee-for-service payment rate increase for inpatient hospital services, effective January 1, 2015. Technical difference – House strikes obsolete references to GAMC (staff recommend House).	**Section 3. Payments.** Amends § 256.969, subd. 3a. Increases MA payment rates for nongovernment-owned hospitals by 30 percent, for inpatient hospital admissions occurring on or after July 1, 2013, through June 30, 2017. Requires these funds to be distributed as follows: (1) 25 percent for an across the board inpatient services rate increase; (2) 9 percent to increase MA rates for nongovernment owned hospitals above the 85th percentile for patient days for patients under 18 years of age in CY 2012;

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			(3) 2 percent to increase MA rates for nongovernment owned hospitals above the 90th percentile for patient days for patients under 18 years of age in CY 2011, for diagnosis-related groups 453 to 517 (e.g. spinal fusion, hip and knee replacement), 533 to 541 (e.g. fractures of femur, hip, and pelvis), 906 (hand procedures for injuries), and 956 (injuries to nerves of pelvis and lower limbs); (4) 14 percent to increase MA rates paid for inpatient mental health and chemical dependency treatment services; (5) 14 percent to increase MA rates paid for inpatient birth and delivery services; (6) 2 percent to increase rates paid to critical access hospitals; (7) 33 percent to increase MA rates paid for services at nongovernment owned hospitals determined to have the most significant losses of Medicare funding in 2013; and (8) 1 percent to increase payment rates for services at nongovernment hospitals that are Level I trauma centers. Provides that prepaid health plan rates shall not be adjusted to reflect these increases. Requires the commissioner to adjust rates and payments in excess of the Medicare upper limits according to § 256.9685, subd. 2. Also strikes obsolete references to general assistance medical care.
4	**(256.969, subd. 29)** increases the payment rates to hospitals to cover the increase to the newborn screening fee that goes toward providing family support services in the early hearing detection and intervention program.	Technical differences in cross-reference to screening fee, reference to public programs, and reference to health plans (staff recommend Senate).	**Section 4. Reimbursement for the fee increase for the early hearing detection and intervention program.** Amends § 256.969, subd. 29. Requires hospital payment rates to be adjusted, for admissions occurring on or after July

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			1, 2013, to include the fee increase for the early hearing detection and intervention program paid by the hospital for public program recipients. Requires the increase to be in effect until it is fully recognized in the base year cost, and requires the payment to be included in payments to contracted managed care organizations.
5	**(256B.055, subd. 14)** specifies that medical assistance covered services received by an inmate of a public institution who otherwise meets the medical assistance eligibility requirements are covered under medical assistance while the inmate is an inpatient of a medical institution.	Senate provision specifically includes costs related to inpatient care are the responsibility of the entity with jurisdiction over the inmate; House does not include this language.	**Section 5. Persons detained by law.** Amends § 256B.055, subdivision 14. Provides that an inmate of a public institution (such as a correctional facility), who meets MA eligibility criteria, is eligible for MA coverage of services received while an inpatient in a medical institution. Under current law, inmates of public institutions are not eligible for MA. States that security issues related to the inpatient treatment of an inmate are the responsibility of the entity with jurisdiction over the inmate. Provides a January 1, 2014 effective date.
6	**(256B.06, subd. 4)** continues to cover dialysis services provided in a hospital or free-standing dialysis facility and surgery and the administration of chemotherapy, radiation, and related services necessary to treat cancer under emergency medical assistance for noncitizens regardless of immigration status. This section also authorizes the payment of follow up care and alternative services that would not otherwise be paid for if the commissioner determines that the services, if provided, would directly prevent a medical emergency from immediately arising.	Senate adds a paragraph (l) that allows the commissioner or a third party medical review agent to authorize payment for follow-up care and alternative services. House does not include this language.	**Section 6. Citizenship requirements.** Amends § 256B.06, subd. 4. Classifies the following as services for the treatment of emergency medical conditions, and therefore eligible for coverage under emergency medical assistance: (1) dialysis services provided in a hospital or freestanding dialysis facility; and (2) surgery and the administration of chemotherapy, radiation, and related services to treat cancer, if the recipient has cancer that is not in remission and these services are required. (Under current law, these services are covered for the period May 1, 2013, through June 30, 2013.) Provides an effective date of July 1, 2013.
		House-only provision	**Section 7. Dental services.** Amends § 256B.0625, subd. 9. Expands MA dental coverage for adults, to include: (1) house calls or extended care facility calls for on-site delivery of covered services;

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			(2) behavioral management, when additional staff time is required and sedation is not used; (3) oral or IV sedation, if the covered service cannot be performed safely without it or would need to be performed under general anesthesia in a hospital or surgical center; and (4) prophylaxis, in accordance with an individualized treatment plan, but no more than four times per year.
7	**(256B.0625, subd. 13e)** modifies the pharmacy reimbursement rate for drugs administered in an outpatient setting and requires the payment to be made to the administering facility or practitioner.	House modifies payment rates for drugs purchased through the 304B program; Senate does not. (Senate has study language on 340B program in section 27.) House and Senate identical in terms of outpatient setting rate changes.	**Section 8. Payment rates.** Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) requires the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program to be estimated at wholesale acquisition cost minus 44 percent, for purposes of MA payment. The amendment to paragraph (d) allows payment for drugs administered in an outpatient setting to be at the lower of the specialty pharmacy rate or the maximum allowable cost (in addition to the lower of the usual and customary cost or 106 percent of the average sales price, as under current law). Requires the commissioner to discount the payment rate for drugs obtained through the federal 340B Drug Discount Program by 33 percent. Requires payment for drugs administered in an outpatient setting to be made to the administering facility or the practitioner. Provides that a retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement. Provides an effective date of January 1, 2014.
8	**(256B.0625, subd. 28b)** extends medical assistance coverage	Senate-only provision	

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	to doula services provided by a certified doula effective July 1, 2014, or upon federal approval, whichever is later.		
9	**(256B.0625, subd. 31)** states that an electronic tablet may be considered a durable medical equipment if the electronic tablet is to be used as an augmentative and alternative communication system. To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.	Identical	**Section 9. Medical supplies and equipment.** Amends § 256B.0625, subd. 31. States that electronic tablets may be considered durable medical equipment if it will be used as an augmentative and alternative communication system and other requirements are met.
10	**(256B.0625, subd. 31b)** requires the commissioner to implement a point of sale preferred diabetic testing supply program by January 1, 2014. Medical assistance coverage for diabetic testing supplies shall conform to the limitations to this program. This section also authorizes the commissioner to enter into a contract with a vendor for the purpose of participating in a preferred diabetic testing supply list and supplemental rebate program.	Technical difference – House refers to the "agency" web site and Senate to the "department's" (staff recommends Senate). Note: in paragraph (b) of both bills, "medial" should be corrected to read "medical."	**Section 10. Preferred diabetic testing supply program.** Amends § 256B.0625, by adding subd. 31b. Requires the commissioner to adopt and implement a point of sale preferred diabetic testing supply program by January 1, 2014. Allows the commissioner to contract with a vendor to participate in a preferred diabetic testing supply list and supplemental rebate program and specifies related requirements. Provides that supplies not on the preferred supply list may be subject to prior authorization. Requires the commissioner to seek any federal waivers and approvals necessary for implementation.
11	**(256B.0625, subd. 39)** eliminates medical assistance coverage for the administration of pediatrics vaccines covered under the pediatric vaccine administration program.	Identical	**Section 11. Childhood immunizations.** Amends § 256B.0625, subd. 39. Strikes language that specifies how much MA will pay per dose for the administration of vaccine to children.
12	**(256B.0625, subd. 58)** eliminates medical assistance payment for an EPSDT screening for vaccines that are available at no cost to the provider.	Identical	**Section 12. Early and periodic screening, diagnosis, and treatment services.** Amends § 256B.0625, subd. 58. Provides that payment for a complete EPSDT screening shall not include charges for vaccines that are available at no cost to the provider.
13	**(256B.0625, subd. 61)** permits the payment for mental health services and dental services provided to a patient by a clinic or health care provider that are provided on the same day as other covered services furnished by the same provider.	Senate permits payment; House requires a study.	**Section 22. Payment for multiple services provided on the same day.** Requires the commissioner of human services to report, by December 15, 2013, to the chairs and ranking minority members of the legislative committees with

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			jurisdiction over health and human services policy and finance, on the costs and savings to MA of allowing payment, including supplemental payments, for mental health or dental services provided to a patient by a federally qualified health center or look-alike, or a rural health clinic, on the same day as other covered services furnished by the same provider.
14	**(256B.0631, subd. 1)** requires the commissioner to waive the collection of the medical assistance family deductible. This section also permits the Hennepin County pilot program to waive the medical assistance co-payments and states that the value of the waived copayments shall not be included as part of the payment system under the pilot program.	Senate requires the commissioner to waive the collection of the family deductible from individuals. House does not. House provides that the value of the copayments shall not be included "in the capitation amount to the managed care organization"; Senate refers to the "payment system for the integrated health care delivery networks under the pilot program." (Staff recommends Senate.)	**Section 13. Cost-sharing.** Amends § 256B.0631, subd. 1. Directs the commissioner of human services, as part of the contracting process for the pilot project to test alternative and innovative health care delivery networks, to allow the Hennepin County pilot program to waive copayments. Provides that the value of the copayments shall not be included in the capitation payment to the managed care organization participating in the project.
15	**(256B.0756)** makes minor changes to the Hennepin County innovative health care delivery network pilot program, including permitting the commissioner to identify individuals to be enrolled in the pilot program by zip code and whether they would benefit from enrolling in the pilot program. This section also lifts the pilot program enrollment cap and strikes obsolete language permitting the county to transfer funds to support the nonfederal share of payments.	House provision refers to identifying individuals based on zip code in Hennepin County; Senate does not specify that the zip code be in Hennepin County. (Staff recommends House).	**Section 14. Hennepin and Ramsey Counties pilot program.** Amends § 256B.0756. Modifies the criteria governing a pilot program operated by Hennepin County to test alternative and innovative health care delivery networks, by: (1) allowing the program to serve MA enrollees beyond those who are adults without children; (2) removing the enrollment cap of 7,000 enrollees; and (3) striking language that allows the county to transfer funds necessary to support the nonfederal share of payments for integrated health care delivery networks. This section also allows the commissioner to identify individuals to be enrolled in the pilot program, based on

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			Hennepin County zip code or whether individuals would benefit from an integrated health care delivery network.
16	**(256B.196, subd. 2)** requires the commissioner to determine an upper payment limit for ambulance services affiliated with Hennepin County Medical Center that is based on the average commercial rate or be determined using another method acceptable to the Centers for Medicare and Medicaid Services. Requires the commissioner to inform Hennepin County of the periodic intergovernmental transfers necessary to match the federal Medicaid payments available in order to make supplementary payments to Hennepin County Medical Center equal to the difference between the established medical assistance payment for ambulance services and the upper payment limit.	Senate-only provision	
17	**(256B.69, subd. 5c)** increases the amount that is transferred by the commissioner to the medical education research cost fund (MERC) by $6.4 million per year.	House increases the amount transferred from capitation payments to MERC to $49.552 million, Senate to $43.148 million.	**Section 15. Medical education and research fund.** Amends § 256B.69, subd. 5c. For FY 2014 and thereafter, increases from $36,744,000 to $49,552,000 the amount transferred from MA capitation payments to the medical education and research fund.
18	**(256B.69, subd. 31)** extends the limits to the trend increases for the rates paid to managed care plans and county-based purchasing plans for calendar years 2016 and 2017 and adds to the reduction to the increases beginning in calendar year 2014 through 2017.	House applies revised trend increase limits to CY 2014 and 2015; Senate extends the limits to CY 2016 and 2017. The bills establish different trend increase limits as follows: • House reduces the limit for MA elderly basic care to 3.25 percent, Senate to 6.0 percent. Senate removes language exempting Medicare cost-sharing, nursing facility, and personal care assistance services. • House reduces the limit for MA special needs basic care to 2.5 percent, Senate of 0.5 percent • Senate reduces the limit for MA families and children	**Section 16. Payment reduction.** Amends § 256B.69, subd. 31. Modifies trend increase limits for managed care and county-based purchasing plan capitation payments, by: (1) changing the effective date for the 2014 limits from July to January 1, 2014; (2) reducing the limit from 7.5 to 3.25 percent for MA elderly basic care; (3) reducing the limit from 5.0 to 2.5 percent for MA special needs basic care; and (4) reducing the limit from 4.0 to 3.0 percent for MinnesotaCare adults without children.

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		to 0.5 percent • Senate reduces the limit for MA adults without children to 0 percent House reduces the limit for MinnesotaCare adults without children to 3.0 percent	
19	**(256B.69, subd. 34)** requires the commissioner to establish risk corridors for each managed care plan and county-based purchasing plan that is calculated annually based on the calendar year's net underwriting gain or loss.	Senate-only provision	
20	**(256B.76, subd. 1)** increases the fee-for-service payment rates for physician and professional services by 5 percent effective January 1, 2015.	Senate-only provision	
21	**(256B.76, subd. 2)** increases payment rates for dental service by five percent effective January 1, 2015.	House payment increase is effective January 1, 2014; Senate, January 1, 2015. Technical differences (staff recommends Senate).	**Section 17. Dental reimbursement.** Amends § 256B.76, subd. 2. Effective January 1, 2014, increases payment rates for dental services by 5 percent. Provides that the increase does not apply to state-operated dental clinics, federally qualified health centers, rural health centers, and Indian health services. Requires payments to managed care and county-based purchasing plans to be adjusted to reflect this payment increase.
22	**(256B.76, subd. 4)** increases the critical access dental payments by 5 percent beginning July 1, 2013, and expands the critical access dental provider designation to include city-owned and operated hospital based dental clinics and to private practicing dentists if the dentist's office is located within a health shortage area, if more than 50 percent of the dentist's patient encounters per year are with patients who are uninsured or covered by medical assistance or MinnesotaCare, the dentist does not restrict access or services because the patient's financial limitations or coverage status, and the level of service provided by the dentist is critical to maintaining adequate	Senate increases critical access payment rate by five percentage points; House does not. House requires individual clinics of a dental group to meet criteria regarding patient encounters; Senate does not. Senate strikes language allowing the commissioner to designate dental providers as critical access providers if they provide care to state health care program enrollees at a level that significantly increases access; House does not.	**Section 18. Critical access dental providers.** Amends § 256B.76, subd. 4. Modifies the definition of critical access dental provider. The amendment to clause (3) includes city owned and operated hospital-based dental clinics. The amendment to clause (4) eliminates the inclusion of clinics or dental groups owned and operated by a nonprofit corporation meeting specified criteria, and instead requires each clinic of the dental group to have more than 50 percent of its patient encounters involve patients who are uninsured or on MA or MinnesotaCare, in order for that clinic to have critical access dental provider status. A new clause (6) classifies private

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	levels of access with the service area in which the dentist operates.		practicing dentists as critical access dental providers, if the office is located in a health professional shortage area, over 50 percent of patient encounters are with the uninsured or MA or MinnesotaCare enrollees, and other criteria are met.
23	**(256B.76, subd. 7)** states that the payment for primary care services and immunization administration services on or after January 1, 2013, through December 31, 2014, shall be increased to meet the federal payment requirements.	Identical	**Section 19. Payment for certain primary care services and immunization administration.** Amends § 256B.76, by adding subd. 7. Requires payment for certain primary care services and immunization administration services provided January 1, 2013, through December 31, 2014, to be made in accordance with § 1902(a)(13) of the Social Security Act (this provision requires primary care services to be paid at a rate not less than Medicare rates for 2013 and 2014).
24	**(256B.764)** increases the family planning rates by 20 percent for services provided by a community clinic. Requires the rates to managed care plans and county based purchasing plans to reflect this increase.	House increase is effective July 1, 2013; Senate, July 1, 2014.	**Section 20. Reimbursement for family planning services.** Amends § 256B.764. Effective July 1, 2013, increases payment rates for family planning services provided by a community clinic by 20 percent. Requires capitation rates to managed care and county-based purchasing plans to be adjusted to reflect this increase, and requires plans to pass on the full amount of the increase to community clinics. Provides a July 1, 2013 effective date.
25	**(256B.766)** increases the fee-for-service payment rates for ambulatory surgery centers, medical supplies, and durable medical equipment not subject to a volume purchase contract, prosthetics and orthotics, hospice services, rental dialysis services, laboratory services, public health nursing services, eyeglasses. and hearing aids not subject to volume purchase contract by three percent effective January 1, 2015.	House increases payment to certain hospitals for basic care services provided to children; Senate provides a fee-for-service payment rate increase for basic care services, generally. Senate modifies current rate reduction by striking hospice services from basic care services.	**Section 21. Reimbursement for basic care services.** Amends § 256B.766. Effective July 1, 2013, increases fee for service payments to pediatric hospitals and nonstate government hospitals located in cities of the first class by 1 percent, for outpatient basic care services provided to persons under age 21. This increase is subject to an aggregate spending limit of $450,000 for the biennium ending June 30, 2015.
26	Requires the Commissioner of Human Services to convene a workgroup to develop a plan to provide coordinated and cost-effective health care and coverage to individuals who are eligible for emergency medical assistance and requires this	Senate requires the commissioner to convene a work group and extends the current study until July 15, 2013. House requires the commissioner to issue a request for	**Section 24. Request for information; emergency medical assistance.** Requires the commissioner of human services to issue a request for information (RFI) to identify and develop options for a program to provide emergency medical

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	plan to be submitted to the legislature by July 15, 2013.	information to identify and develop options for a program to provide EMA recipients with coverage for services not eligible for FFP.	assistance recipients with coverage for medically necessary services not eligible for federal financial participation. Requires the RFI to be issued by August 1, 2013, and specifies criteria for the RFI. Requires the commissioner, based on responses to the RFI, to submit recommendations on providing this coverage for emergency medical assistance recipients to legislative chairs by January 15, 2014.
27	Modifies the transfer language that was enacted earlier this session in Laws 2013, chapter 1, chapter 6, that transfers funds from the health care access fund to the general fund for the medical assistance costs associated with adding the 19 and 20 year olds and parent and relative caretaker populations with income between 100 and 138 percent of FPG.	Senate-only provision	
28	Requires the Commissioner of Human Services to study and make recommendations to the legislature on changes to standardize the medical assistance reimbursement rates for prescription drugs obtained through the 340B program and dispensed to medical assistance enrollees.	Senate-only provision (House modifies 340B payment rates in section 8).	
29	Requires the Commissioner of Human Services to study and make recommendations to the legislature on the current oral health and dental services delivery system for the state public health care programs to improve access and ensure cost effective delivery of services. The study must include modifying the delivery of services and reimbursement systems including modifications to the critical access dental provider payments.	House study focuses more on the feasibility of a single administrator approach for dental services. Senate adds this to one of the areas that should be studied. Differences between House and Senate in terms of the areas that are to be addressed in the study.	**Section 23. Dental administration and reimbursement report.** Requires the commissioner of human services to study the feasibility of a single dental administrator for all dental services provided under MA and MinnesotaCare. Specifies criteria for the study and requires the report and recommendations to be submitted to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 15, 2013.
30	Requires nonprofit organizations that receive state grant funds from either the Commissioner of Human Services or Health to post the organization's 990 tax form on its Web site, if the organization has a Web site.	Senate-only provision	