# Bill Summary Comparison of Health and Human Services

House File 2128-4
## Article 1: DHS Health Care Programs

Senate File UEH2128-1
## Article 1: Health Care; Department of Human Services

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| Section | Article 1: DHS Health Care Programs | | Article 1: Health Care; Department of Human Services |
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| **1** | **Applicability of chapter.**<br>Adds § 62A.002. Provides that any benefit or coverage mandate in this chapter (regulation of health insurers) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees. | Page R1: House only | |
| **2** | **Applicability.**<br>Amends § 62C.01, by adding subd. 4. Provides that any benefit or coverage mandate in this chapter (regulation of nonprofit health service plan corporations) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees. | Page R1: House only | |
| **3** | **Applicability.**<br>Amends § 62D.01, by adding subd. 3. Provides that any benefit or coverage mandate in this chapter (regulation of HMOs) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees. | Page R1: House only | |
| **4** | **Applicability of chapter.**<br>Adds § 62J.011. Provides that any benefit or coverage mandate in this chapter (dealing with health care cost containment, health information technology, administrative simplification, patient protection, and other topics) does not apply to managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees. | Page R1: House only | |
| **5** | **Applicability of chapter.**<br>Amends § 62Q.02. Provides that any benefit or coverage mandate in this chapter (health plan companies) does not apply to | Page R1: House only | |

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| | managed care or county-based purchasing plans, when the plan is providing coverage to MA or MinnesotaCare enrollees. | | |
| **6** | **Other standards; wheelchair securement; protected transport.**<br>Amends § 174.30, subd. 3. Makes a conforming change in a cross-reference to MA nonemergency medical transportation coverage. | Page R2: House only | |
| | | For Senate sections 1 to 7, see comparison of House article 12 and Senate article 13. | |
| **7** | **Statewide health information exchange.**<br>Amends § 256.01, subd. 28. Gives the commissioner the authority to develop and operate, as part of a statewide health information exchange, an encounter alerting service. | Page R2: Identical | **Section 8 (256.01, subd. 28)** authorizes the expansion of the Minnesota encounter alerting system to improve care and lower health care costs. |
| | | Page R2: Senate only | **Section 9 (256.01, subd. 42) paragraph (a)** specifies that for any mandated report that does not include a specific expiration date the expiration dates specified in this subdivision apply.<br>**Paragraph (b)** any report mandate enacted before January 1, 2021, shall expire on January 1, 2023 if the report is required annually and shall expire on January 1, 2024 if the report is required biennially or less frequently.<br>**Paragraph (c)** any report mandate enacted on or after January 1,2021 expires three years after the date of enactment if the report is required annually and expires five years after the date of enactment if the report is required biennially or less frequently.<br>**Paragraph (d)** requires the commissioner to submit a list to the legislature by February 15 of each year beginning February 15, 2022 of all reports set to expire |

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| | | | during the following calendar year. |
| | | For Senate sections 10 and 11, see comparisons of House article 12 and Senate article 13, and House article 5 and Senate article 4. | |
| **8** | **Hospital payment rates.**<br>Amends § 256.969, subd. 2b. Allows the commissioner, when rebasing inpatient hospital payment rates, to combine claims from two consecutive years if claims volume for a single year falls below the threshold needed for a statistically valid sample. Prohibits the use of years in which claims volume is reduced or altered due to a pandemic or public health emergency, if the base year includes more than one year. | Page R3: House only | |
| **9** | **Alternate inpatient payment rate.**<br>Amends § 256.969, by adding subd. 2f. Requires the commissioner, effective July 1, 2021, to reduce the disproportionate share hospital (DSH) payment by 99 percent for a hospital with an MA utilization rate at least two and one-half standard deviations above the statewide mean, and compute an alternative inpatient payment rate for that hospital. The alternative payment rate must target total aggregate reimbursement equal to what the hospital would have received for fee-for-service inpatient services had the hospital received the full DSH payment. Specifies a January 1, 2022, effective date. | Page R6: Identical | **Section 12 (256.969, subdivision 2f)** requires the commissioner to reduce by 99 percent the disproportionate share hospital (DSH) payments received by Hennepin Healthcare, and replace Hennepin Healthcare's lost DSH revenue with an alternative inpatient payment rate of comparable value. |
| **10** | **Disproportionate numbers of low-income patients served.**<br>Amends § 256.969, subd. 9. Modifies the provisions governing disproportionate share hospital (DSH) payments, by: (1) basing the DSH adjustment for providing transplant services on all MA payments including managed care, not just fee-for-service payment; (2) clarifying an existing DSH payment for a hospital (HCMC) with an MA utilization rate at least 2.5 standard | Page R7: House only | |

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| | deviations above the statewide mean by adding the requirement that this hospital be a level one trauma center; and (3) specifying that the MA utilization rate and discharge thresholds used to determine eligibility for various DSH factors are to be measured using only one year, when a two-year base period is used. Provides that these provisions are effective July 1, 2021.<br><br>Increases, from $1.5 million to $9.75 million in fiscal year 2023 and $14 million beginning July 1, 2023, the amount of a payment adjustment for disproportionate share hospitals with high levels of administering high-cost drugs to MA fee-for-service enrollees (the adjustment takes into account as one factor 340B drug payments). Also allows a children's hospital that qualifies for an alternate inpatient payment rate to be eligible for this DSH payment. Provides that these provisions are effective January 1, 2023. | | |
| **11** | **Appeals.**<br>Amends § 256.9695, subd. 1. Extends from 12 to 18 months the time period, after the last day of the calendar year that is the base year, during which hospitals can appeal base year information used to set inpatient hospital payment rates. | Page R9: Identical | **Section 13 (256.9695, subd. 1)** expands the period in which hospitals may appeal or correct the information that the commissioner uses to set the rates and the overall budget pool for inpatient hospital services from 12 months to 18 months. |
| **12** | **Fraud prevention investigations.**<br>Amends § 256.983. Includes tribal agencies as recipients of fraud prevention investigation grant funding, and requires tribal agencies to comply with the same requirements that apply to county grant recipients. | Page R9: Identical | **Section 14 (256.983)** expands the fraud and prevention investigation programs to include tribal agencies. |
| **13** | **Administration of dental services.**<br>Adds § 256B.0371. (a) Effective January 1, 2023, requires the commissioner to contract with a dental administrator to administer dental services for MA and MinnesotaCare enrollees, | Page R11: House only | |

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| | including those persons enrolled in managed care as described in § 256B.69.<br><br>(b) Requires the administrator to provide administrative services, including but not limited to: provider recruitment, contracting, and assistance; recipient outreach and assistance; utilization management and reviews of medical necessity; claims processing; service coordination; management of fraud and abuse; monitoring access to services; performance measurement; quality improvement and evaluation; and management of third-party liability requirements.<br><br>(c) Sets payment rates at the MA rate as established under section 256B.76.<br><br>Provides a January 1, 2023, effective date. | | |
| **14** | **Limitation on services.**<br>Amends § 256B.04, subd. 12. Strikes outdated language related to service delivery and reimbursement for emergency and nonemergency transportation providers, and other providers. | Page R12: House only | |
| **15** | **Competitive bidding.**<br>Amends § 256B.04, subd. 14. Allows the commissioner to volume purchase through competitive bidding and negotiation allergen-reducing products as described in section 256B.0625, subd. 67, paragraph (c) or (d).<br><br>Allows the commissioner to use volume purchase through competitive bidding for nonemergency medical transportation generally (current law limits this to level of need determinations, disbursement of public transportation passes and tokens, and volunteer and recipient mileage and parking reimbursement). Also eliminates the specific prohibition on the use of volume | Page R12: House only | |

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| | purchase through competitive bidding for special transportation services. | | |
| **16** | **Pregnant women; needy unborn child.**<br>Amends § 256B.055, subd. 6. Extends MA coverage for pregnant women from 60 days to 12 months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later. | Page R13: House extends coverage to 12 months postpartum; Senate to six months postpartum. | **Section 15 (256B.055, subd. 6)** expands medical assistance eligibility for pregnant women to include six months postpartum, effective July 1, 2022. |
| **17** | **Eligibility verification.**<br>Amends § 256B.056, subd. 10. Makes a conforming change related to the extension of MA coverage for pregnant women to 12 months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later. | Page R14: House refers to a 12-month postpartum period; Senate to a six-month postpartum period. | **Section 16 (256B.056, subd. 10)** makes a conforming change to the expansion of eligibility to six months postpartum by requiring a woman to update their income and asset information following the end of the six months. |
| **18** | **Qualified Medicare beneficiaries.**<br>Amends § 256B.057, subd. 3. Sets the asset limit for eligibility for Medicare savings programs (programs that assist low-income Medicare beneficiaries with Medicare premiums and cost-sharing) at the current level -- $10,000 for one and $18,000 for two or more individuals, or at the asset level for the Medicare Part D extra help low income subsidy (LIS), once this indexed asset level exceeds the current asset limits. States that this section is effective the day following final enactment. | Page R14: Identical | **Section 17 (256B.057, subd. 3)** aligns eligibility asset limits for qualified Medicare beneficiaries to the federal limits. |
| **19** | **Citizenship requirements.**<br>Amends § 256B.06, subd. 4. Makes a conforming change related to the extension of MA coverage for pregnant women to 12 months postpartum. States that the section is effective January 1, 2022, or upon federal approval, whichever is later. | Page R15: House refers to 12 months of postpartum coverage; Senate to six months of postpartum coverage. | **Section 18 (256B.06, subd. 4)** makes a conforming change to the expansion of eligibility to six months postpartum for non-citizens. |
| **20** | **Health Services Advisory Council.** | Page R19: Identical | **Section 19 (256B.0625, subd. 3c)** changes the name of the health services policy committee to the health services advisory council; adds as a duty of the committee to advise the |

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| | Amends § 256B.0625, subd. 3c. Makes a number of changes related to the Health Services Advisory Council. These include:<br>▪ renaming the Health Services Policy Committee the Health Services Advisory Council;<br>▪ requiring the council to advise the commissioner on evidence-based decision-making and health care benefit and coverage policies for Minnesota health care programs;<br>▪ eliminating language that requires the chair to be a physician;<br>▪ allowing the council to monitor and track practice patterns of health care providers generally (current law allows this for physicians); and<br>▪ striking obsolete language and making conforming and related changes. | | commissioner on evidence based decision making and health care benefit and coverage policies for Minnesota health care programs. Makes other minor changes and strikes obsolete language. |
| **21** | **Health Services Advisory Council members.**<br>Amends § 256B.0625, subd. 3d. Modifies council membership by:<br>▪ reducing the number of physicians from seven to six, and striking the requirement that one physician be actively engaged in treating persons with mental illness;<br>▪ adding one member who is a health care or mental health professional actively engaged in treating persons with mental illness; and<br>▪ increasing the number of consumer members from one to two.<br>Also clarifies what constitutes a quorum and renames the committee. | Page R20: Identical | **Section 20 (256B.0625, subd. 3d)** changes the membership the committee by reducing the number of licensed physicians from seven to six; adding an additional voting member of the committee who is a health care or mental health professional actively engaged in Minnesota in the treatment of persons with mental illness; and adding another consumer as a voting member. It also clarifies that no member of the committee shall be employed by the state of Minnesota except for the medical director and what constitutes a quorum. |

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| **22** | **Health Services Advisory Council.**<br>Amends § 256B.0625, subd. 3e. Renames the Health Services Advisory Committee the Health Services Advisory Council and makes conforming changes. | Page R21: Identical | **Section 21 (256B.0625, subd. 3e)** makes conforming changes to the name change. |
| **23** | **Dental services.**<br>Amends § 256B.0625, subd. 9. Requires the commissioner to contract with a dental administrator for the administration of dental services, including the administration of dental services for persons enrolled in managed care as described in § 256B.69. Makes conforming changes. Provides that these provisions are effective January 1, 2023.<br><br>Expands MA coverage of dental services for nonpregnant adults, to include coverage of nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures. This expansion of coverage also applies to the MinnesotaCare program, through cross-reference elsewhere in statute. Provides that these provisions are effective July 1, 2021. | Page R21: House only: requires the commissioner to contract with a dental administrator effective January 1, 2023.<br><br>Both House and Senate expand adult dental services to include coverage for periodontal disease (language is identical). | **Section 22 (256B.0625, subd. 9)** expands adult dental medical assistance coverage to include nonsurgical treatment for periodontal disease. |
| | | Page R23: Senate only | **Section 23 (256B.0625, subd. 9c)** requires the commissioner to develop uniform prior authorization criteria for dental services requiring prior authorization. |
| | | Page R24: Senate only | **Section 24 (256B.0625, subd. 9d)** requires the commissioner to develop a uniform credentialing process for dental providers. |
| **24** | **Drugs.**<br>Amends § 256B.0625, subd. 13. Allows a 90-day supply of a prescription drug to be dispensed under MA, if the drug appears on the 90-day supply list published by the commissioner. Requires the list to be published on the DHS website. Allows the commissioner to modify the list after providing public notice and | Page R24: Both House and Senate allow the dispensing of a 90-day supply of certain cost-effective generic drugs; language is identical. | **Section 25 (256B.0625, subd. 13)** authorizes prescription refills of 90 days for drugs included on a 90-day supply list published by the commissioner. |

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| | a 15-day comment period. Provides that the list may include cost-effective generic drugs, but shall not include controlled substances.<br><br>Requires each 340B covered entity and ambulatory pharmacy under common ownership of the covered entity to report to the commissioner, by March 1 of each year, reimbursement for the previous calendar year from each managed care and county-based purchasing plan, or from the PBM under contract with the plan. Requires the aggregate cost of drugs purchased through the 340B program, and other specified information, to be reported. Directs the commissioner to submit a copy of the reports to the legislature, by April 1 of each year. States that 340B drugs acquired and dispensed by a 340B covered entity or ambulatory pharmacy under -common ownership are not eligible for coverage if the covered entity fails to submit the required report. | House-only provision: requires 340B covered entities to report specified drug reimbursement information to DHS, and requires DHS to report to the legislature. | |
| **25** | **Formulary Committee.**<br>Amends § 256B.0625, subd. 13c. Removes the June 30, 2022, expiration date for the Formulary Committee, and provides that the committee does not expire. | Page R27: House makes the formulary committee ongoing; Senate keeps the current expiration date of June 30, 2022, and makes a technical change. Staff recommend Senate on the technical change. | **Section 26 (256B.0625, subd. 13c)** makes a technical correction. |
| **26** | **Drug formulary.**<br>Amends § 256B.0625, subd. 13d. Allows MA to cover drugs or active pharmaceutical ingredients used for weight loss. Under current law, the MA formulary only covers drugs for weight loss if they are medically necessary lipase inhibitors used by recipients with Type II diabetes. | Page R27: House only | |
| **27** | **Payment rates.**<br>Amends § 256B.0625, subd. 13e. Increases the dispensing fee for prescription drugs from $10.48 to $10.77. Also requires the | Page R28: Identical | **Section 27 (256B.0625, subd. 13e)** increases the dispensing fee for prescriptions dispensed under the fee for service system from $10.48 to $10.77. This section also requires the commissioner when conducting the cost of dispensing survey required to be conducted on all pharmacies every three years to measure a single statewide cost of dispensing for specialty |

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| | statewide cost of dispensing to be calculated separately for specialty and nonspecialty drugs. | | prescription drugs and a single cost of dispensing for non-specialty prescription drugs. |
| | | Page R31: Senate only | **Section 28 (256B.0625, subd. 13g)** requires the commissioner before deleting a drug from the preferred drug list or modifying the inclusion of a drug on the list to consult with the commissioner of health to determine the implications the change may have on state public health policies and initiatives. The section also requires the commissioner to conduct a public hearing and to provide public notice prior to the hearing that includes the deletion or modification being considered and the information being relied on by the commissioner in proposing the deletion or modification. |
| | | Page R31: Senate only | **Section 29 (256B.0625, subd. 13k)** requires a pharmacy to be licensed by the board of pharmacy and located within the state to be an eligible dispensing provider under the medical assistance and MinnesotaCare programs. |
| **28** | **Transportation costs.**<br>Amends § 256B.0625, subd. 17. Makes various changes to MA coverage of NEMT services, including changes related to the use of an administrator. These changes include:<br>▪ striking references to the Nonemergency Medical Transportation Advisory Committee (this committee is repealed elsewhere in the article);<br>▪ striking references to the single administrative structure;<br>▪ replacing a reference to "local agency" with a reference to the "administrator" and striking a provision designating the local agency as the single administrative agency; and | Page R32: House only | |

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| | ▪ striking the existing language on NEMT reimbursement for the various modes of service.<br><br>States that the section is effective January 1, 2023. | | |
| **29** | **Documentation required.**<br>Amends § 256B.0625, subd. 17b. Allows funds paid for NEMT transportation that is not documented to be recovered by the NEMT vendor, as well as the department. States that the section is effective January 1, 2023. | Page R36: House only | |
| **30** | **Public transit or taxicab transportation.**<br>Amends § 256B.0625, subd. 18. Allows the commissioner to provide a monthly public transit pass for the nonemergency medical transportation needs of MA recipients who are well-served by public transit. Provides that recipients are eligible for a transit pass if they are eligible for one public transit trip for a covered service during a month, and have not received a transit pass for that month from another program administered by a county or tribe. These recipients are then not eligible for other modes of transportation, unless an unexpected need arises that cannot be accessed through public transit. Prohibits the commissioner from requiring recipients to select a transit pass, if their transportation needs cannot be served by public transit. States that this section is effective January 1, 2022. | Page R37: House only | |
| **31** | **Administration of nonemergency medical transportation.**<br>Amends § 256B.0625, subd. 18b. Requires the commissioner to contract, either statewide or regionally, for the administration of the NEMT program. Specifies that the contract must also include administration of all covered modes of NEMT services for those enrolled in managed care under § 256B.69. Also strikes language that limited the use of a broker or coordinator for NEMT services | Page R38: House only | |

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| | to establishing the level of service. States that the section is effective January 1, 2023. | | |
| **32** | **Other clinic services.**<br>Amends § 2567B.0625, subd. 30. For purposes of rebasing encounter rates for federally qualified health centers (FQHCs) and rural health clinics, prohibits the use of years in which costs or claims volume is reduced or altered due to a pandemic, disease, or other public health emergency, when the base year includes more than one year. Allows the commissioner to use Medicare cost reports of a year unaffected by pandemic, disease, or other public health emergency, or the previous two consecutive years, inflated to the base year. | Page R38: House only | |
| **33** | **Medical supplies and equipment.**<br>Amends § 256B.0625, subd. 31. States that allergen-reducing products provided according to subd. 67, paragraph (c) or (d), shall be considered durable medical equipment. States that the section is effective January 1, 2022, or upon federal approval, whichever is later. | Page R43: House only | |
| **34** | **Early and periodic screening, diagnosis, and treatment services.**<br>Amends § 256B.0625, subd. 58. (a) Requires the commissioner, in administering the EPSDT program, to, at a minimum:<br>1) provide information to children and families on the benefits of preventative visits, services available, and assistance in finding a provider, transportation, or interpreter services;<br>2) maintain an up-to-date periodicity schedule in the department policy manual; and | Page R45: House only | |

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| | 3) maintain up-to-date policies for providers on delivering EPSDT services that are in the provider manual on the department website.<br><br>(b) Allows the commissioner to contract for the administration of outreach services as required by the EPSDT program.<br><br>(c) Allows the commissioner to contract for required EPSDT outreach services, including but not limited to children enrolled in or attributed to an integrated health partnership (IHP) demonstration project. Requires IHPs that choose to provide EPSDT outreach services to receive compensation from the commissioner on a per-member, per-month basis for each child. Specifies related requirements. Provides that this paragraph is effective January 1, 2022. | | |
| **35** | **Enhanced asthma care services.**<br>Amends § 256B.0625, by adding subd. 67. (a) States that MA covers enhanced asthma care services and related products provided in children's homes for children with poorly controlled asthma. To be eligible, requires a child:<br><br>1) to have poorly controlled asthma, defined as having received asthma care from a hospital emergency department at least once in the past year or having been hospitalized for the treatment of asthma at least once in the past year; and<br><br>2) to have received a referral for services and products under this subdivision from a treating health care provider.<br><br>(b) States that covered services include home visits provided by a registered environmental health specialist or lead risk assessor | Page R46: House only | |

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| | credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.<br><br>(c) Requires covered products to be identified and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health professional providing asthma care, and proven to reduce asthma triggers. Lists specific products covered.<br><br>(d) Requires the commissioner to determine other products that may be covered, as new best practices for asthma are identified.<br><br>(e) Defines a home assessment as a home visit to identify asthma triggers and to provide education on trigger-reducing products. Limits a child to two home assessments, except that an additional home assessment may be provided if the child moves to a new home, a new asthma trigger enters the home, or if the child's health care provider identifies a new allergy for the child. Requires the commissioner to determine the frequency with which a child may receive a product listed in paragraph (c) or (d), based on the reasonable expected lifetime of the product.<br><br>States that the section is effective January 1, 2022, or upon federal approval, whichever is later. | | |
| | | For Senate section 30, see comparison of House article 12 and Senate article 13 | |
| **36** | **Cost-sharing.**<br>Amends § 256B.0631, subd. 1. Exempts medications when used to prevent or treat HIV from MA copayments. States that the section is effective January 1, 2022, subject to federal approval. | Page R47: House only | |

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| **37** | **Opioid prescribing work group.**<br>Amends § 256B.0638, subd. 3. Adds to the opioid prescribing work group two consumer members who are Minnesota residents and who have used or are using opioids to manage chronic pain. Also adds a representative of the Minnesota Department of Health as a nonvoting member. | Page R48: Identical | **Section 31 (256B.0638, subd. 3)** changes the membership of the opiate epidemic response advisory council by adding two consumer members who are Minnesota residents and have used or are using opioids to manage chronic pain and adding a member representing the commissioner of health. |
| **38** | **Program implementation.**<br>Amends § 256B.0638, subd. 5. Modifies the procedure used to report opioid prescriber data, by requiring the commissioner to report to provider groups data on individual prescribers' prescribing patterns, and requiring provider groups to distribute this data to prescribers. Under current law, the commissioner reports to prescribers. | Page R49: Identical | **Section 32 (256B.0638, subd. 5)** specifies that commissioner shall annually report to provider groups the sentinel measures of data showing individual provider's opioid prescribing patterns and then requires the provider groups to distribute data to the individual providers. |
| **39** | **Data practices.**<br>Amends § 256B.0638, subd. 6. Allows the commissioner to share with provider groups data on prescribers' prescribing patterns. Under current law, the information shared is limited to information on prescribers who are subject to quality improvement activities. | Page R50: Identical | **Section 33 (256B.0638, subd. 6)** makes a corresponding change. |
| **40** | **Qualified professional; qualifications.**<br>Amends § 256B.0659, subd. 13. Eliminates a requirement that DHS enroll qualified professionals who work for personal care assistance provider agencies. Requires qualified professionals to meet provider training requirements and strikes outdated language. | Page R50: Identical | **Section 34 (256B.0659, subd. 13)** clarifies that a personal care assistant must clear a background study and meet provider training requirements and eliminates the requirement that the personal care attendant enroll with the department as a qualified professional. |
| | | For Senate sections 35 and 36, see comparison of House article 12 and Senate article 13. | |
| **41** | **Commissioner's duties.** | Page R52: House provides a January 1, 2022, effective date and also makes implementation contingent upon federal | **Section 37 (256B.196, subdivision 2, paragraph (c))** ends Hennepin Healthcare's authority to use intergovernmental |

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| | Amends § 256B.196, subd. 2. Removes Hennepin County from an existing voluntary intergovernmental transfer, under which Hennepin County would transfer to the commissioner $12 million per year. Provides that this section is effective January 1, 2022, or upon federal approval of this section and § 256B.1973, whichever is later. | approval of section 256B.1973; Senate provides a December 31, 2021, effective date. Otherwise identical. | transfers to fund managed care passthroughs. These managed care passthroughs are in the process of being phased out. The phase-out schedule for Regions Hospital remains unchanged. |
| **42** | **Directed payment arrangements.**<br>Adds § 256B.1973.<br>**Subd. 1. Definitions.** Defines the following terms: billing professionals, health plan, and high medical assistance utilization.<br>**Subd. 2. Federal approval required.** States that each directed payment arrangement under this section is contingent on federal approval and must conform with the requirements for permissible directed managed care organization expenditures.<br>**Subd. 3. Eligible providers.** States that eligible providers under this section are nonstate government teaching hospitals with high MA utilization and a level I trauma center, and the hospital's affiliated billing professionals, ambulance services, and clinics.<br>**Subd. 4. Voluntary intergovernmental transfers.** Allows a nonstate governmental entity eligible to perform intergovernmental transfers to make voluntary intergovernmental transfers to the commissioner. Requires the commissioner to inform the entity of the transfers necessary to maximize the allowable directed payments. | Page R54: House and Senate have same general intent, but there are various differences.<br>Subd. 1 to 4: Identical<br>Subd. 5: House in (a) specifies how the uniform adjustment factor is to be determined; Senate does not. House allows use of an annual settle-up process; Senate specifies the process may be no less than annually. House specifies that the payment be specific to each plan and prospectively incorporated into capitation rates; Senate does not.<br>Paragraph (b), requiring the commissioner to ensure that payments at least equal the sum of the intergovernmental transfer and federal participation, is Senate-only.<br>House (b) and Senate (c) are identical.<br>Subd. 6 and 7: Identical<br>Subd. 8: House requires the commissioner, in consultation with Hennepin Healthcare, to submit a methodology to measure access and achievement of quality goals to CMS; Senate requires these three entities to develop mutually agreed upon measures. | **Section 38 (256B.1973)** requires, with federal approval, the commissioner of human services to direct certain managed care organization expenditures to Hennepin Healthcare through an arrangement known as a state-directed fee schedule.<br>**Subdivision 1** defines "billing professional," "health plan," and "high medical assistance utilization" for the purposes of this section.<br>**Subdivision 2** requires federal approval before implementation of any directed payment arrangement.<br>**Subdivision 3** defines providers who may participate in a directed payment arrangement. Currently, only Hennepin Healthcare meets the definition.<br>**Subdivision 4** permits a nonstate government entity, such as Hennepin Healthcare, to make voluntary intergovernmental transfers to maximize the value of allowable directed payments.<br>**Subdivision 5 to 6** requires health plans to submit claims data from Hennepin Healthcare to the commissioner; requires the commissioner to determine a fee-schedule for services provided by Hennepin Healthcare to the MA population to maximize allowable directed payments; requires the commissioner to increase capitation rates to health plans to account for the fee schedule; and requires the health plans to reimburse Hennepin Healthcare |

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| | **Subd. 5. Commissioner's duties; state-directed fee schedule requirement.** (a) Requires the commissioner, for each federally approved directed payment arrangement that is a state-directed fee schedule requirement, to determine a uniform adjustment factor for each claim submitted to a health plan and to apply this to each claim. Directs the commissioner to ensure that the adjustment factor maximizes the allowable directed payments and does not result in payments exceeding federal limits, and allows the commissioner to use a settle-up process to adjust health plan payments to comply with this requirement.<br><br>(b) Requires the commissioner to develop a plan for initial implementation of the state-directed fee schedule requirement to ensure that eligible providers receive the entire permissible value under each arrangement. If federal approval is retroactive, requires the commissioner to make a onetime pro rata increase in the adjustment factor and initial payments.<br><br>**Subd. 6. Health plan duties; submission of claims.** Requires each health plan to submit to the commissioner payment information for each claim paid to an eligible provider for MA services.<br><br>**Subd. 7. Health plan duties; directed payments.** Requires each health plan to make directed payments to the eligible provider in an amount equal to the payment amounts the plan received from the commissioner.<br><br>**Subd. 8. State quality goals.** Requires the directed payment arrangement and the state-directed fee schedule requirement to align with state quality goals for Hennepin | Also technical differences in phrasing; staff recommend House.<br><br>Technical differences in referring to a retroactive effective date; staff recommend Senate. | according to the fee schedule.<br><br>**Subdivision 8** requires that the directed payment arrangement and state-directed fee schedule meets a federal requirement for such an arrangement by aligning with state quality goals for Hennepin Healthcare. |

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| | Healthcare MA patients. Specifies related requirements and quality measure domains.<br><br>States that this section is effective January 1, 2022, or upon federal approval, whichever is later, and allows for retroactive implementation. | | |
| **43** | **Prescription drugs.**<br>Amends § 256B.69, subd. 6d. Requires the commissioner to exclude (carve out) outpatient drugs from MA managed care contracts. States that the section is effective January 1, 2023, or upon completion of the Medicaid Management Information System pharmacy module modernization project, whichever is later. | Page R56: Different intent. House directs the commissioner to exclude outpatient prescription drugs dispensed to MA enrollees from PMAP contracts.<br><br>Senate requires managed care and county-based purchasing plans, or the plan's subcontractor, to comply with § 256B.0625, subd. 13k (Senate section 29: criteria that must be met to be a dispensing provider). | **Section 39 (256B.69, subd. 6d)** requires managed care plans and county-based purchasing plans to comply with section 256B.0625, subd. 13k (licensed in state pharmacies) for purposes of contracting with dispensing providers. |
| | | Page R57: Senate only | **Section 40 (256B.69, subd. 6f)** requires applicable fee schedules for covered dental services to be provided to individual dental providers upon request. |
| **44** | **Annual report on provider reimbursement rates.**<br>Amends § 256B.69, by adding subd. 9f. (a) Requires the commissioner, by December 15 of each year, to report to the legislature on managed care and county-based purchasing plan provider reimbursement rates. Requires compliance with general requirements for reports to the legislature (e.g. transmittal to Legislative Reference Library, statement of cost).<br><br>(b) Requires the report to include, for each managed care and county-based purchasing plan, the mean provider reimbursement rates by county for the preceding calendar year, for the five most common billing codes statewide across all plans, for the following categories: (1) physician services – prenatal and preventive; (2) physician services – nonprenatal and | Page R57: House only | |

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| | nonpreventive; (3) dental services; (4) inpatient hospital services; (5) outpatient hospital services; and (6) mental health services.<br><br>(c) Requires the commissioner to also include in the report: (1) the mean and median reimbursement rates by county for the preceding calendar year for the billing codes and service categories described in paragraph (b); and (2) the mean and median fee-for-service reimbursement rates by county for the preceding calendar year for the billing codes and service categories described in paragraph (b). | | |
| **45** | **Annual report on prepaid health plan reimbursement to 340B covered entities.**<br>Amends § 256B.69, by adding subd. 9g. (a) Requires managed care and county-based purchasing plans, by March 1 of each year, to report to the commissioner their reimbursement to 340B covered entities for the previous calendar year. Specifies the information that must be reported.<br><br>(b) Requires the commissioner to submit a copy of the reports to the legislature by April 1 of each year. | Page R58: House only | |
| **46** | **Direction of managed care organization expenditures.**<br>Amends § 256B.6928, subd. 5. Allows the commissioner to direct managed care organization expenditures as permitted under the federal rule governing Medicaid directed payments (42 CFR 438.6(c)). | Page R58: Identical | **Section 41 (256B.6928, subdivision 5)** clarifies that certain state-directed managed care expenditures are permitted under federal law. |
| **47** | **Hospital outpatient reimbursement.**<br>Amends § 256B.75. Effective for services provided on or after July 1, 2023, requires payments to critical access hospitals for outpatient, emergency, and ambulatory surgery facility fee services to be increased for hospitals providing high levels of high-cost or 340B drugs. Requires the adjustment to be based on | Page R59: Both House and Senate have identical provisions related to the use of methods and parameters similar to Medicare.<br><br>House only provision: rate increase for outpatient and other services for hospitals providing high levels of high-cost or 340B drugs. | **Section 42 (256B.75)** describes the rate methods and rate calculation parameters that the commissioner must use to set prospective payment methodologies for services delivered in outpatient hospital and ambulatory surgical centers. |

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| | each hospital's share of total reimbursement for 340B drugs to all critical access hospitals, but not to exceed three percentage points.<br><br>Directs the commissioner, when implementing prospective payment methodologies for outpatient hospital services, to use general methods and rate calculation parameters similar to the applicable Medicare prospective payment systems for outpatient hospital and ambulatory surgical center settings, unless other payment methodologies are specified in state MA law. | | |
| **48** | **Dental reimbursement.**<br>Amends § 256B.76, subd. 2. Sunsets existing MA dental payment rates effective January 1, 2023.<br><br>A new paragraph (l) sets payments for dental services provided on or after January 1, 2023, at the lower of the submitted charge or 86 percent of the fifth percentile of 2018 submitted charges. Requires the commissioner to increase this payment by 20 percent for critical access dental providers under MA and MinnesotaCare, and requires this add-on to be calculated to be specific to each individual clinic location within a larger system. States that this paragraph does not apply to FQHCs, rural health centers, state-operated dental clinics, or Indian health centers.<br><br>A new paragraph (m) requires dental payment rates to be rebased beginning January 1, 2026, and every four years thereafter, to the first percentile of submitted charges for the applicable base year (the calendar year two years prior to the effective date of rebasing). | Page R61: House only | |
| **49** | **Critical access dental providers.** | Page R63: House only | |

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| | Amends § 256B.76, subd. 4. Provides that MA critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law). | | |
| **50** | **Definitions.**<br>Amends § 256B.79, subd. 1. Modifies the definition of "targeted populations" for the integrated care for high-risk pregnant women grant program, to refer to pregnant MA enrollees residing in "communities" rather than "geographic areas." | Page R65: House only | |
| **51** | **Grant awards.**<br>Amends § 256B.79, subd. 3. Strikes language that requires integrated perinatal care collaboratives that received grants prior to January 1, 2019, to be given priority when determining subsequent grants. | Page R65: House only | |
| | | Page R65: Senate only | **Section 43 (256B.795)** requires the commissioner to submit a biennial report to the legislature on the number of pregnant and postpartum women enrolled in MA who received certain benchmark services or treatment during the reporting period. |
| **52** | **Income.**<br>Amends § 256L.01, subd. 5. Defines "income" under MinnesotaCare as projected annual income for the applicable tax year, and strikes references to current income and income during the 12-month eligibility period. Provides that the section is effective the day following final enactment. (The changes in this section and the sections related to income limit adjustments and eligibility redetermination that follow reflect the failure of the Centers for Medicare and Medicaid Services to approve Minnesota eligibility determination changes passed in 2016 and reflected in current law.) | Page R66: Identical | **Section 44 (256L.01, subd. 5)** clarifies that income means a household's projected annual income for the applicable year. |

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| **53** | **Cost-sharing.**<br>Amends § 256L.03, subd. 5. Exempts from MinnesotaCare co-payments pre-exposure prophylaxis (PrEP) and postexposure prophylaxis (PEP) medications when used for the prevention or treatment of HIV. States that the section is effective January 1, 2022, subject to federal approval. | Page R66: House only | |
| **54** | **Annual income limits adjustment.**<br>Amends § 256L.04, subd. 7b. Requires the commissioner to adjust MinnesotaCare income limits annually on January 1, rather than each July 1. Provides that the section is effective the day following final enactment. | Page R67: Identical | **Section 45 (256L.04, subd. 7b)** requires the commissioner to adjust the income limits annually on January 1, instead of July 1. |
| **55** | **Redetermination of eligibility.**<br>Amends § 256L.05, subd. 3a. Specifies that the period of MinnesotaCare eligibility is the calendar year, and that eligibility redeterminations shall occur during the open enrollment period for qualified health plans. Strikes language that defined the period of eligibility as the 12-month period beginning the month of application, with renewals being implemented throughout the year. Provides that the section is effective the day following final enactment. | Page R67: Identical | **Section 46 (256L.05, subd. 3a)** requires redetermination of eligibility to occur during the open enrollment period for qualified health plans. |
| **56** | **Must not have access to employer-subsidized minimum essential coverage.**<br>Amends § 256L.07, subd. 2. A new paragraph (b) allows an individual who has access to subsidized health coverage through a spouse's or parent's employer that meets the requirements of minimum essential coverage under federal regulations, to be eligible for MinnesotaCare, if the amount the employee pays for employee and dependent coverage exceeds the required income contribution for determining whether employer coverage is affordable under the ACA. Under current law, only the amount | Page R67: House only | |

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| | paid for employee coverage would be considered when determining affordability.<br><br>Provides an effective date of January 1, 2022. | | |
| **57** | **Dental providers.**<br>Amends § 256L.11, subd. 6a. Provides that the MinnesotaCare dental payment rate increase of 54 percent is in effect only through December 31, 2022 (these payments are ongoing under current law). | Page R68: House only | |
| **58** | **Critical access dental providers.**<br>Amends § 256L.11, subd. 7. Provides that MinnesotaCare critical access dental payments are in effect only through December 31, 2022 (these payments are ongoing under current law). | Page R68: House only | |
| **59** | **Sliding fee scale; monthly individual or family income.**<br>Amends § 256L.15, subd. 2. Requires the commissioner, retroactive to January 1, 2021, to adjust the MinnesotaCare premium schedule to ensure that MinnesotaCare premiums do not exceed the amount an individual would have been required to pay if they were enrolled in an applicable benchmark plan. States that this section is effective the day following final enactment. | Page R68: Technical differences only; staff recommend Senate. | **Section 47 (256L.15, subd. 2)** requires the commissioner to adjust the premium scale for MinnesotaCare to ensure that premiums are not greater than what an individual would be required to pay for a benchmark plan in the exchange. |
| | | Page R69: Senate only | **Section 48 (256L.15, subd. 5)** establishes a tobacco use premium surcharge for tobacco users in MinnesotaCare that equals 10% of the enrollee's monthly premium effective January 1, 2023. Specifies that tobacco product does not include the use of tobacco by American Indians as part of a traditional spiritual or cultural ceremony. |
| **60** | **Exclusions and exemptions.**<br>Amends § 295.53, subd. 1. Excludes from the MinnesotaCare provider tax directed payments authorized under § 256B.1973. | Page R70: Technical differences only, related to retroactive implementation; staff recommend House. | **Section 49 (295.53, subdivision 1)** expands an existing exemption from the gross revenues subject to the hospital, surgical center, or health care provider taxes to include the |

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| | States that this section is effective for taxable years beginning after December 31, 2021. | | state-directed managed care expenditures authorized under the new directed payment arrangement under section 256B.1973. |
| **61** | **Court ruling on Affordable Care Act.**<br>In the event the U.S. Supreme Court reverses the Affordable Care Act (ACA), requires the commissioner of human services to take all actions necessary to maintain current MA and MinnesotaCare policies, including pursuing federal funds or, if federal funds are not available, using state funds for at least a year following the Supreme Court decision or until the conclusion of the next regular legislative session, whichever is later. | Page R72: House only | |
| **62** | **Delivery reform analysis report.**<br>Requires the commissioner of human services to present to the legislature, by January 15, 2023, a report comparing service delivery and payment models for MinnesotaCare and certain MA enrollees. Specifies report requirements. | Page R72: House only | |
| **63** | **Dental home demonstration project.**<br>Requires the Dental Services Advisory Committee, in collaboration with specified stakeholders, to design a dental home demonstration project and present recommendations by February 1, 2022, to the commissioner and legislature. Specifies requirements for the demonstration projects. | Page R73: Same general intent but numerous differences.<br>▪ House requires the Dental Services Advisory Committee to conduct the study; Senate requires the commissioner.<br>▪ Differences in phrasing, emphasis, and structure between House and Senate related to goals of the demonstration project.<br>▪ Senate directs the commissioner to develop outcome measures; House does not.<br>▪ Differences in the list of entities the commissioner or advisory committee must consult. House requires consultation with clinics for which the public program caseload is less than 25 percent; Senate does not. House identifies specific educational programs; Senate includes a general reference. | **Section 51 [Dental home demonstration project plan]** requires the commissioner to develop a plan to implement a dental home demonstration project. |

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| | | House includes as stakeholders MDH and specific associations; Senate does not.<br>▪ House requires reporting to the legislative committees with jurisdiction over health finance and policy; Senate to health and human services policy and finance. | |
| **64** | **Direction to commissioner; income and asset exclusion for St. Paul guaranteed income demonstration project.**<br>**Subd. 1. Definitions.** Defines the terms "commissioner" and "guaranteed income demonstration project."<br><br>**Subd. 2. Commissioner; income and asset exclusion.** Paragraph (a) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for child care assistance programs and MFIP, the work benefit program, or DWP.<br><br>Paragraph (b) prohibits the commissioner from counting payments made to families by the guaranteed income demonstration project as income or assets for purposes of determining or redetermining eligibility for MA or MinnesotaCare.<br><br>**Subd. 3. Report.** Requires the city of St. Paul to provide a report to the legislative committees with jurisdiction over human services policy and finance by February 15, 2023, with information on the progress and outcomes of the guaranteed income demonstration project.<br><br>**Subd. 4. Expiration.** Makes this section expire June 30, 2023. | Page R75: House only | |

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| | Provides a July 1, 2021, effective date, except for subdivision 2, paragraph (b), which is effective July 1, 2021, or upon federal approval, whichever is later. | | |
| **65** | **Expansion of outpatient drug carve out; prescription drug purchasing program.**<br>Requires the commissioner of human services, in consultation with the commissioners of commerce and health, to assess and develop recommendations related to: (1) expanding the managed care drug carve out to include MinnesotaCare; and (2) establishing a prescription drug purchasing program to serve persons with private sector insurance coverage. Specifies criteria for the recommendations and requires a report to the legislature by December 15, 2023. | Page R76: House only | |
| | | Page R76: Senate only | **Section 50 [Capitation payment delay]** delays a portion of the medical assistance capitation payment to managed care plans and county-based purchasing plans due in May 2023 and May 2025 until July 2023 and July 2025, respectively. |
| **66** | **Federal approval; extension of postpartum coverage.**<br>Requires the commissioner of human services to seek all federal waivers and approvals necessary to extend MA coverage for pregnant women to 12 months postpartum. States that the section is effective the day following final enactment. | Page R76: Technical differences only; staff recommend House. | **Section 52 [Federal Approval; extension of postpartum coverage]** requires the commissioner of human services to seek federal approval to extend medic al assistance postpartum coverage. |
| **67** | **Proposal for a public option.**<br>Requires the commissioner of human services, in consultation with other entities, to develop a proposal for a public option program. Specifies requirements for the public option and public option proposals. Requires the commissioner to report to the legislature by December 15, 2021. | Page R76: House only | |

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| **68** | **Response to COVID-19 public health emergency.**<br>(a) Prohibits the commissioner from collecting any unpaid premium under MA employer persons with disabilities or MinnesotaCare, for a coverage month that occurred during the federal COVID-19 public health emergency.<br><br>(b) Allows the commissioner to suspend periodic data matching for up to six months following the last day of the federal COVID-19 public health emergency.<br><br>(c) Suspends the requirement that the commissioner issue an annual report on periodic data matching, for one year following the last day of the federal COVID-19 public health emergency.<br><br>**Provides that this section is effective the day following final enactment, except that paragraph (a) as it relates to MinnesotaCare premiums is effective upon federal approval.** | Page R78: House only | |
| | | Page R78: Senate only | **Section 53 [Overpayments for durable medical equipment]** requires the commissioner of human services to repay the federal government any amount owed for payments made in excess to the allowable reimbursement amount for payments made between January 1, 2018 and June 30, 2019 for durable medical equipment. |
| | | Page R79: Senate only | **Section 54 [Proposed formulary committee]** requires the commissioner of human services to submit to the legislature a proposed reorganization of the drug formulary committee to ensure adequate representation by consumers and health care professionals and to ensure public input. |
| | | For Senate section 55, see comparison of House article 12 and Senate article 13. | |
| | | Page R79: Senate only | **Section 56 [Direction to commissioner; directed payment application]** requires the commissioner of human services to |

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| | | | submit by July 31, 2022 the necessary materials seeking approval from to the Centers for Medicare and Medicaid Services for the state-directed managed care expenditures under section 256B.1973. |
| | | For Senate section 57, see comparison of House article 12 and Senate article 13. | |
| | | Page R79: Senate only | **Section 58 [Direction to commissioner of human services; funding for recuperative care]** requires the commissioner of human services to develop an MA reimbursable recuperative care service to serve individuals with chronic conditions who lack a permanent residence at the time of discharge. Provides that the section is contingent on the receipt of nonstate funding. |
| | | For Senate section 59, see comparison of House article 12 and Senate article 13. | |
| **69** | **Revisor instruction.**<br>Directs the revisor to change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever it appears in law, and make conforming changes. | Page R79: Identical | **Section 60 [Revisor instruction]** requires the revisor to change the name of the health services policy committee to the health services advisory council. |
| **70** | **Repealer.**<br>(a) Repeals rules related to the EPSDT program, effective July 1, 2021.<br><br>(b) Repeals § 256B.0625, subd. 18c (nonemergency medical transportation advisory committee), 18d (advisory committee members), 18e (single administrative structure and delivery system for NEMT), and 18h (NEMT provisions applicable to managed care and county-based purchasing plans). Provides a January 1, 2023, effective date. | Page R79: House repeals rules related to the EPSDT program and certain NEMT provisions.<br><br>Senate repeals a statutory transfer from the HCAF to the GF effective July 1, 2024; the House in Article 21, section 25 repeals this provision June 30, 2025. | **Section 61 [Repealer]** repeals section 16A.724, subd. 2 effective July 1, 2024, which requires an annual transfer from the health care access fund to the general fund. |