

1.1 moves to amend H.F. No. 3546 as follows:

1.2 Delete everything after the enacting clause and insert:

1.3 "Section 1. **[256B.044] PREPAYMENT REVIEW.**

1.4 Subdivision 1. **Providers subject to prepayment review.** (a) The commissioner must
1.5 establish prepayment review of submitted medical assistance claims when the commissioner
1.6 or the Centers for Medicare and Medicaid Services designates:

1.7 (1) a provider type as high-risk under section 256B.04, subdivision 21, paragraph (j),
1.8 for fee-for-service claims submitted by providers within that category; and

1.9 (2) a covered service as high-risk, for fee-for-service claims submitted for that service
1.10 by any provider, except the Indian Health Service.

1.11 (b) Nothing in this section prevents the commissioner from establishing prepayment
1.12 review in other circumstances if required by the Centers for Medicare and Medicaid Services.

1.13 Subd. 2. **Review requirements.** (a) The commissioner must implement a prepayment
1.14 review established under subdivision 1, paragraph (a), within 15 days of the date of the
1.15 high-risk designation, effective for a period of up to 24 months from the date the review is
1.16 implemented.

1.17 (b) A prepayment review established under subdivision 1, paragraph (a), must comply
1.18 with the timely processing of claims requirements under Code of Federal Regulations, title
1.19 42, section 447.45.

1.20 (c) Before ending prepayment review under subdivision 1, paragraph (a), clause (1), the
1.21 commissioner must review all fee-for-service claims submitted by providers subject to the
1.22 prepayment review in the 24 months preceding the date the provider type was designated
1.23 high-risk.

2.1 Subd. 3. Continued enrollment of new clients. Nothing in this section prohibits an
2.2 enrolled provider that is subject to prepayment review under subdivision 1, paragraph (a),
2.3 from enrolling new clients or beneficiaries during the period of the review.

2.4 Subd. 4. Notice. At least ten days prior to implementing a prepayment review, the
2.5 commissioner must notify enrolled providers subject to the review and the chairs and ranking
2.6 minority members of the legislative committees with jurisdiction over health and human
2.7 services policy and finance about the prepayment review the commissioner plans to
2.8 implement under this section. The notice must:

2.9 (1) include a list of provider types or covered services to which prepayment review
2.10 applies;

2.11 (2) provide a general explanation for the basis of the review; and

2.12 (3) identify the start date and anticipated duration of the prepayment review.

2.13 Subd. 5. Report to the legislature. (a) Within 60 days of ending a prepayment review,
2.14 the commissioner must submit a report to the chairs and ranking minority members of the
2.15 legislative committees with jurisdiction over health and human services policy and finance.
2.16 The report must include, at a minimum:

2.17 (1) a summary of any sanctions imposed under section 256B.064 on any providers subject
2.18 to prepayment review; and

2.19 (2) recommendations for modifying or terminating the provision of covered services
2.20 deemed high-risk or delivered by provider types subject to prepayment review.

2.21 (b) Notwithstanding section 256.01, subdivision 42, this subdivision does not expire."

2.22 Amend the title accordingly