Bill Summary Comparison of

Health and Human Services

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| Senate File: 800-3 | House File: UES0800-2 |
| Article 4: Health Care | Article 1: Health Care |

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| Article 4: Health Care |  | Article 1: Health Care |
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|  | House-only provision. (Senate § 1 requires the OLA to audit managed care organizations.) | Sec. 1. Audits of the Department of Human Services (DHS). Amends § 3.972, by adding subd. 2a. (a) Directs the legislative auditor to give high priority to auditing the programs, services, and benefits administered by DHS, in order to ensure continuous legislative oversight and accountability. Requires the audits to determine whether DHS offered programs and provided services and benefits only to eligible persons and organizations, and complied with applicable legal requirements.  (b) Requires the legislative auditor, no less than three times each year, to test a representative sample of MA and MinnesotaCare enrollees, to determine whether they are eligible to receive benefits under those programs. Requires the legislative auditor to report the results to the commissioner of human services and recommend corrective actions, which the commissioner must implement within 20 business days. Requires the legislative auditor to monitor implementation of corrective actions and periodically report to the legislative audit commission and the legislative committees with jurisdiction over health and human services policy and finance. Requires these reports to include recommendations for any legislative actions needed to ensure that MA and MinnesotaCare benefits are provided only to eligible persons. |
|  |  | Sec. 2 is compared in the comparison summary of Senate article 8/House article 6. |
| **Section 1 (3.972 subdivision 2b)** requires the legislative auditor to audit each managed care organization that contracts with the Commissioner of Human Services to provide services under sections 256B.69, 56B.692, and 256L.12. | Senate-only provision. (House Article 1, § 1 requires the OLA to audit representative samples of MA and MinnesotaCare enrollees.) |  |
| **Section 2 (13.69, subdivision 1)** permits the Department of Public Safety to share social security numbers, which are otherwise classified as private government data of the Department of Public Safety, with the Department of human services for the purposes recovering medical assistance benefits provided to medical assistance recipients injured in motor vehicle accidents. | Senate-only provision |  |
| **Section 3 (62J.815)** requires health care providers to maintain a list of services and procedures that correspond with the provider’s 35 most frequent CPT codes and the ten most frequent CPT codes for preventive services used for reimbursement, and the provider’s charges for each of these services that the provider would charge a patient who did not have coverage and make the list available to the public. | Senate-only provision |  |
| **Section 4 (62U.02, subdivision 1)** requires the Commissioner of Health to establish statewide measures for use by health plan companies that assess the quality of health care services offered by health care providers.  Requires that the statewide measures must (1) for the purposes of assessing the quality of care provided at physician clinics, be selected from the available measures as defined in federal regulations, unless the stakeholders determine that a particular diagnosis, condition, service, or procedure is not reflected in any of the available measures in a way that meets identified needs; (2) be based on medical evidence; and (3) be developed through a process in which providers participate in and consumer and community input and perspectives are obtained.  This subdivision also requires the commissioner to develop a measurement framework by June 30, 2018, that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders.  By December 15, 2018, the commissioner must use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including providers certified as health care homes.  The commissioner shall develop the framework in consultation with the stakeholders and must review the framework at least once every three years and shall report to the legislature by September 30, 2018, summarizing the development of the measurement framework and making recommendations on the type and appropriate maximum number of measures in the statewide measurement set.  **Subdivision 3** requires the commissioner to issue periodic public reports on trends in provider quality at the statewide, regional, and clinic levels.  This subdivision also requires physician clinics and hospitals to submit standardized information for the identified statewide measures to the commissioner in the formats specified by the commissioner or the commissioner’s designee which must include alternative formats for clinics or hospitals experiencing technological or economic barriers to submission in standardized electronic form.  The commissioner shall ensure that any quality data reporting requirements for physician clinics are aligned with the specifications and timelines for the selected measures and may develop additional data on race, ethnicity, preferred language, country of origin, or other sociodemographic factors.  None of the statewide measures selected shall require providers to use an external vendor to administer or collect data.  **Subdivision 5** makes minor changes by removing obsolete language and referring to a standard set of measures. | Senate-only provision |  |
| **Section 5 (62V.05, subdivision 12)** removes the requirement that the MNsure Board provide the legislature with copies of certain agreements. | Senate-only provision |  |
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| Section 6 [256.01, subdivision 18f] requires the Commissioner of Human Services to implement an Asset Verification System to verify the assets of persons who are blind, persons age 65 and older, and persons with disabilities applying for or renewing benefits under medical assistance. | Senate-only provision |  |
| **Section 7 (256.01, subdivision 41)** removes the requirement that the Commissioner of Human Services provide the legislature with copies of certain agreements. | Senate-only provision |  |
|  | House-only provision | Sec. 3. Rate year. Amends § 256.9686, subd. 8. Defines “rate year” as the state fiscal year, effective with the 2012 base year. Provides an immediate effective date. |
|  | House-only provision | Sec. 4. Hospital cost index. Amends § 256.969, subd. 1. Allows automatic inflation adjustments for hospital payment rates, if authorized by this section of law. Provides a July 1, 2017, effective date. |
| **Section 8 (256.969, subdivision 2b)** delays the next hospital rebasing by 4 years **until July 1, 2021**. | House extends DHS authority to use payment rate adjusters for an additional rebasing period; Senate does not.  Senate delays rebasing for four years; House does not.  House also includes language related to calculation of per discharge rates, measuring changes in costs between base years, and rates for critical access hospitals; Senate does not. | Sec. 5. Hospital payment rates. Amends § 256.969, subd. 2b. The amendment to (e) extends the period by which the commissioner may make additional adjustments to rebased rates, to include the next two rebasing periods (current law allows this until the next rebasing).  The amendment to (f) provides that for determining rates for discharges in subsequent base years, the per discharge rates shall be based on Medicare cost-finding methods and allowable costs.  The amendment to (h) requires changes in costs between base years to be measured using the lower of the change in the CMS Inpatient Hospital Market Basket or the change in the case mix adjusted cost per claim.  The amendment to (i) clarifies that it is “inpatient” rates for critical access hospitals that are to be determine using the new cost-based methodology.  Provides a July 1, 2017, effective date. |
| **Section 9 [256.969, subdivision 2e)** creates a contingent alternative payment rate for children’s hospitals that is retroactive to rate years beginning on or after January 1, 2015.  **Paragraph (a)** specifies a trigger for the calculation of an alternative payment rate for children’s hospitals.  The trigger is any requirement that the days, costs, and revenue associated with MA-eligible patients who also have private health insurance be included in a children’s hospital’s disproportionate share hospital (DSH) payment limit.  If these days, costs, and revenue are included, then the commissioner must calculate the alternative payment rate described in paragraph (b), compare the alternative rate to the DSH rate, and reimburse the children’s hospital at the higher rate.  **Paragraph (b)** specifies the alternative rate, prohibits a children’s hospital from receiving payments under both the alternative rate and the DSH rate, and directs the commissioner to consider the interaction of the alternative rate and inflation adjustments whenever hospital rates are rebased. | Technical differences – staff recommend Senate.  (S.F. 1616 passed Senate floor – language is identical to Senate section 9.) | Sec. 6. Alternate inpatient payment rate. Amends § 256.969, by adding subd. 2e. (a) Establishes a contingent, alternate inpatient payment rate for children’s hospitals that would be implemented retroactively to January 1, 2015, if these hospitals are required to include the days, costs, and revenues of patients eligible for MA who also have private health insurance in the calculation of the DSH rate. Requires the commissioner to reimburse a hospital at the higher of the alternate payment rate or the DSH rate.  (b) Provides that:  (1) the alternative payment rate target an aggregate reimbursement amount that is two percent less than each hospital’s cost coverage percentage under fee-for-service MA;  (2) costs be determined using the MA cost report, with costs determined using Medicare methods, and that the Medicare Cost Report is to be used if the MA cost report is not available;  (3) DSH payments shall not be made in any rate year in which a hospital is paid under the alternate payment rate; and  (4) if the alternative payment amount increases at a rate higher than the inflation factor used in rebasing, the commissioner shall consider this when setting rates at the next rebasing. |
|  | House-only provision | Sec. 7. Payments. Amends § 256.969, subd. 3a. Effective for discharges on or after July 1, 2017, requires rate adjustments for long-term hospitals to be incorporated into the rates and not applied to each claim. Provides a July 1, 2017, effective date. |
| **Section 10 (256.969, subdivision 4b)** requires children’s hospitals to submit annual medical assistance cost reports within six months of the end of the hospital’s fiscal year. | Identical, except for effective date. Senate provision is effective 7-1-17; House retroactive from 1-1-15.  (S.F. 1616 passed Senate floor – identical to House language.) | Sec. 8. Medical assistance cost reports for services. Amends § 256.969, subd. 4b. Requires children’s hospitals to file medical assistance cost reports with the commissioner. Under current law, these hospitals file MA cost reports due to their receiving DSH payments. Provides a retroactive effective date of January 1, 2015. |
|  | House-only provision | Sec. 9. Unusual length of stay experience. Amends § 256.969, subd. 8. Requires the commissioner to establish outlier payment rates for admissions that result in long length of stays (current law refers only to transfers). Provides a July 1, 2017, effective date. |
|  | House-only provision | Sec. 10. Hospital residents. Amends § 256.969, subd. 8c. Effective for discharges on or after July 1, 2017, requires payment for long stays to equal the payments established under the DRG system for unusual length of stay. Provides a July 1, 2017, effective date. |
|  | House-only provision | Sec. 11. Disproportionate numbers of low-income patients served. Amends § 256.969, subd. 9. Makes a technical change in the terminology used to refer to nonchildren’s hospitals. Provides a July 1, 2017, effective date. |
|  | House-only provision | Sec. 12. Rehabilitation hospitals and distinct parts. Amends § 256.969, subd. 12. Effective for discharges on or after July 1, 2017, requires payment to rehabilitation hospitals to be established using the DRG methodology. Provides a July 1, 2017, effective date. |
| **Section 11 (256B.0371, subdivision 1)** requires the commissioner to contract with up to two dental administrators to administer dental services for all recipients of medical assistance and MinnesotaCare.  **Subdivision 2, paragraph (a)**, specifies that recipients shall be given a choice of dental provider who agrees to the requirements and payment rate of this section.  Also requires the administrator to comply with network adequacy geographic access, and essential community provider requirements that apply to managed care organizations for nondental services.  **Paragraph (b)** requires the commissioner to implement this section in consultation with representatives of dental providers who provide dental services to patients enrolled in medical assistance and MinnesotaCare.  **Paragraph (c)** requires the commissioner to consult with county-based purchasing plans on the development and review of a request for proposals and development of metrics to evaluate the performance of a dental administrator. | Senate-only provision |  |
|  | House-only provision | Sec. 13. Limitation on service. Amends § 256B.04, subd. 12. Strikes language requiring DHS to adopt rules that would reimburse nonemergency medical transportation providers at a lower rate for additional passengers. |
| **Section 12 (256B.04, subdivision 21)** updates and clarifies provider enrollment, reenrollment, and revalidation requirements for medical assistance and MinnesotaCare providers. | Senate-only provision |  |
| **Section 13 (256B.04, subdivision 22)** updates the personal care assistance revalidation process to require revalidation at least every three years. | Senate-only provision |  |
| **Section 14 (256B.056, subdivision 5c)** increases the medical assistance excess income standard (aka spenddown) for persons with a disability who are blind or who are over 64 years of age, from 80 percent of federal poverty guidelines to 81 percent, effective June 1, 2019. | Senate-only provision |  |
| **Section 15 (256B.0621, subdivision 10)** allows medical assistance reimbursement for interactive video for relocation case management services, that helps recipients gain access to needed services and supports if they choose to move from an institution to the community. | Identical, except for effective date. Senate states that the section is effective three months after federal approval; House effective date is 7-1-17. | Article 6, sec. 13. Payment rates. Amends § 256B.0621, subd. 10. Adds that in assisting a client who is moving from an institutional setting to the community, a case manager may bill medical assistance for relocation targeted case management services conducted by interactive video as provided in section 256B.0924, subdivision 4a. |
| **Section 16 (256B.0625, subdivision 3b)** includes in the definition of “licensed health care provider” for telemedicine services covered under medical assistance, services provided by a mental health provider. | Technical differences in definition of provider – staff recommend House.  Senate specifies an immediate effective date; House 7-1-17. | Sec. 14. Telemedicine services. Amends § 256B.0625, subd. 3b. Allows mental health practitioners, working under the general supervision of a mental health professional, to provide telemedicine services under MA. |
| **Section 17 (256B.0625, subdivision 7)** eliminate a cross-reference to the home care nursing interpreter-communicator service which is being repealed. | Senate-only provision |  |
|  | House-only provision | Sec. 15. Drugs. Amends § 256B.0625, subd. 13. Strikes the quantity limit for dispensing of over-the-counter medications. |
|  | House-only provision | Sec. 16. Payment rates. Amends § 256B.0625, subd. 13e. The amendment to paragraph (a) sets the basis for determining drug payment, effective April 1, 2017, or upon federal approval, at the lower of the ingredient cost, plus a fixed dispensing fee; or the usual and customary price charged to the public. Sets the professional dispensing fee at $11.35 for drugs that meet the federal definition of “covered outpatient drug.” (The current MA dispensing fee is $3.65.) Sets the dispensing fee for certain intravenous solutions at $11.35 per bag (this varies under current law based on the product). Also sets the dispensing fee at $11.35 for over-the-counter drugs that meet the covered outpatient drug definition at $11.35, subject to pro-ration for smaller quantities. Sets the dispensing fee for over-the-counter drugs that do not meet the covered outpatient drug definition at $3.65, with pro-ration for small quantities. Requires the National Average Drug Acquisition Cost (NADAC) to be used to determine the ingredient cost of a drug. Sets the ingredient cost at wholesale acquisition cost minus two percent for drugs for which a NADAC is not reported. Sets the ingredient cost of drugs acquired through the 340B program at that program’s maximum allowable cost. Requires the maximum allowable cost of a multisource drug to be comparable to the actual acquisition cost, and no higher than the NADAC of the generic product.  The amendment to paragraph (c) strikes language related to payment under a unit dose blister card system.  The amendment to paragraph (d) includes the NADAC of the generic product as one of the pricing factors for the ingredient cost of multisource drugs.  The amendment to paragraph (f) allows the commissioner to establish maximum allowable cost rates for specialty pharmacy products that are lower than the ingredient cost formulas and sets criteria for providers of these products. Also makes conforming changes.  A new paragraph (h) requires the commissioner, for prescriptions filled on or after April 1, 2017, or upon federal approval, to increase ingredient cost reimbursement by two percent for drugs subject to the wholesale drug distributor tax under section 295.52.  States that the section is effective retroactively from April 1, 2017, or from the effective date of federal approval. |
|  | House-only provision | Sec. 17. Transportation costs. Amends § 256B.0625, subd. 17.  The amendment to paragraph (b) makes a change in terminology and clarifies that taxicabs must meet the MA requirements for nonemergency medical transportation (NEMT).  The amendment to paragraph (g) includes the securement of car seats in the list of driver-assisted services.  The amendment to paragraph (i) strikes language that prohibits implementation of the covered modes of transportation, without a new rate structure.  A new paragraph (q) requires the commissioner, when determining NEMT reimbursement rates, to exempt the covered modes of transportation from an MA rule that sets payment rates and requires pro-rating for transporting two or more persons. |
|  | House-only provision | Sec. 18. Documentation required. Amends § 256B.0625, subd. 17b. Makes a conforming change related to implementation of all modes of NEMT. |
|  | House-only provision | Sec. 19. Nursing facility transports. Amends § 256B.0625, by adding subd. 17c. Exempts from level of need determinations Minnesota health care program enrollees who are residing in, or being discharged from, a nursing facility. States that these individuals are eligible for NEMT services until they no longer reside in a nursing facility. |
|  | House-only provision | Sec. 20. Managed care. Amends § 256B.0626, subd. 18h. Lists the MA provisions related to NEMT services that managed care and county-based purchasing plans must comply with (current law specifies the provisions from which these plans are exempt). A new paragraph (b) requires NEMT providers to comply with special transportation services standards, but exempts publicly operated transit systems, volunteers, and not-for-hire vehicles from this requirement. Provides an immediate effective date. |
| **Section 18 (256B.0625, subdivision 20)** modifies the mental health case management section of law to allow medical assistance reimbursement for contact by interactive video, that meet the requirements of section 256B.0625, subdivision 20b. | Identical, except for effective date. Senate states that the section is effective three months after federal approval; House effective date is 7-1-17. | Article 6, sec. 14. Mental health case management. Amends § 256B.0625, subd. 20. Provides that medical assistance and MinnesotaCare will pay for mental health case management services provided by interactive video if the interactive video contact meets the requirements of subdivision 20b. |
| **Section 19 (256B.0625, subdivision 20b)** adds a new subdivision creating a new benefit under the medical assistance chapter for mental health targeted case management through interactive video. | Identical except for effective date. Senate provision is effective three months after federal approval; House 7-1-17. | Article 6, sec. 15. Mental health targeted case management through interactive video. Amends § 256B.0625, by adding subd. 20b. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.  Paragraph (b) allows the person receiving services the right to consent to use of interactive video and to refuse the use of interactive video at any time.  Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.  Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video. |
|  | House-only provision | Sec. 21. Other clinic services. Amends § 256B.0625, subd. 30. The amendment to paragraph (f) places a December 31, 2018, sunset on a provision that allows FQHCs and rural health clinics to be paid under a prospective payment system or an alternative payment methodology.  A new paragraph (g) allows FQHCs and rural health clinics to elect to be paid, for services provided on or after January 1, 2019, under a prospective payment system or the alternative payment methodology established in existing law (as provided in paragraph (f)), or a new alternative payment methodology established in paragraph (l).  The amendment to paragraph (i) requires FQHCs and rural health clinics to submit claims for services provided on or after July 1, 2017, directly to the commissioner for payment. Requires the commissioner to provide claims information to managed care and county-based purchasing plans.  A new paragraph (l) establishes a new alternative payment methodology for FQHCs and rural health clinics. This paragraph:  (1) requires each FQHC and rural health clinic to receive a single medical and a single dental organization rate;  (2) requires the commissioner to reimburse FQHCs and rural health clinics for allowable costs, and specifies these costs;  (3) sets criteria for base year payment rates;  (4) requires the commissioner to annually inflate payment rates and specifies the method to be used;  (5) requires payment rates to be rebased every two years, and adjusted biannually;  (6) requires the commissioner to seek approval from the Centers for Medicare and Medicaid Services to modify payments to FQHCs and rural health clinics according to subdivision 63 (allowing payment for mental health or dental services provided on the same day as other covered services);  (7) requires the commissioner to reimburse FQHCs and rural health clinics for an additional two percent of their medical and dental rates, only if the MinnesotaCare provider tax is required to be paid;  (8) specifies criteria for FQHCs and rural health clinics seeking a change in scope of services; and  (9) specifies criteria for establishing rates for new FQHCs and rural health clinics.  This section also replaces the term “federally qualified health center” with the acronym FQHC throughout, and makes conforming changes. |
|  |  | Sec. 22 is compared in the comparison summary of Senate article 8/House article 6. |
| **Section 20 (256B.0625, subdivision 56a**) allows medical assistance to cover post arrest community- based service coordination for an individual who has been identified as having a mental illness or substance abuse; does not require the security of a public detention facility and is not considered an inmate of a public institution; meet eligibly requirements in section 256b.056; and has agreed to participate in postarrest community-based service coordination through a diversion contract in lieu of incarceration.  Specifies that the nonfederal share of cost for postarrest community-based service coordination services shall be provided by the recipient’s count of residence. | Senate-only provision |  |
| **Section 21 (256B.0625, subdivision 57)** excludes from Medicare part B crossover claims limit to the medical assistance total allowed payments to Indian Health Services. | Senate-only provision |  |
|  | House-only provision  (S.F. 93 is on Senate floor.) | Sec. 23. Community medical response emergency medical technician services. Amends § 256B.0625, subd. 60a. Expands CEMT covered services under MA to include post-discharge visits following discharge from a skilled nursing facility. (Under current law, only hospital post-discharge visits are covered.) Changes terminology to refer to a CEMT as a community medical response emergency medical technician. Also makes conforming changes. |
| **Section 22 (256B.0625, subdivision 64)** authorizes the coverage of stiripentol by the EPSDT program under certain conditions. | Technical differences in format and phrasing – staff recommend Senate. | Sec. 24. Investigational drugs, biological products, and devices. Amends § 256B.0625, subd. 64. Allows the EPSDT program to cover stiripentol only:  (1) when determined to be medically necessary;  (2) for enrollees with Dravet syndrome or certain children with Malignant Migrating Epilepsy in Infancy;  (3) if all other covered prescription medications have been tried without successful outcomes; and  (4) if the U.S. Food and Drug Administration has approved the treating physician’s individual patient new drug application for the use of stiripentol for treatment.  Provides that the MinnesotaCare program does not cover stiripentol. |
|  | House-only provision | Sec. 25. Reimbursement under other state health care programs. Amends § 256B.0644. Exempts dental providers providing dental services outside of the seven-county metropolitan area from the requirement that they participate as a provider in MA and MinnesotaCare, in order to participate as a provider in insurance plans and programs for state employees, the public employees insurance program, insurance plans for local government and school district employees, the workers’ compensation system, and MCHA. Provides that the section is effective upon any necessary federal waiver or approval. |
| **Section 23 (256B.0659, subdivision 21)** requires personal care assistance provider agencies to maintain bonds and insurances for each practice location and authorizes the commissioner to deny medical assistance payments during times of non-compliance with the bond and insurance requirements or to suspend and terminate providers who display patterns of noncompliance with the bond and insurance requirements. | Senate-only provision |  |
| **Section 24 (256B.072)** modifies the measures used for the performance reporting system for inpatient hospitals by requiring that the measures used are consistent with the statewide measures under section 62U.02, subd.1. Requires the commissioner to consider and adjust availability metrics and benchmarks for providers who primarily serve socioeconomically complex patient populations and request to be scored on these additional measures. | Senate makes the use of certain performance measures permissive and requires measures to be consistent with § 62U.02, subd. 1, para. (a), cl. (1) (see section 4).  House in (f) prohibits the assessment of patient satisfaction with pain management when determining compensation or quality incentive payments.  Senate (f) and House subd. 2 are similar but have drafting differences (House references to programs and enrollees are more specific.) | Article 7, sec. 4. Performance reporting and quality improvement system. Amends § 256B.072. Prohibits the assessment of patient satisfaction with pain management to be used in determining compensation or quality incentive payments under MA and MinnesotaCare. Directs the commissioner to require managed care and county-based purchasing plans, and integrated health partnerships, to comply with this prohibition as a condition of contract. States that the prohibition does not apply to: (1) assessing patient satisfaction with pain management for the purpose of quality improvement; and (2) pain management as part of a palliative care plan to treats patient with cancer or receiving hospice care.  A new subdivision 2 requires the commissioner, by January 1, 2019, to consider and appropriately adjust quality metrics and benchmarks for providers who primarily serve socio-economically complex populations and request to be scored on these additional measures. Specifies that this requirement applies to all MA and MinnesotaCare programs and enrollees. |
| **Section 25 (256B.0755, subdivision 1)** changes terminology from “health care delivery systems” to “integrated health partnerships” or IHPs, and specifies that an IHP may be customized for special needs and barriers of patient populations experiencing health disparities due to social, economic, racial, or ethnic factors. | Both Senate and House, throughout § 256B.0755, change the name of the health care delivery system demonstration project to integrated health partnership demonstration project. Senate amends specific subdivisions, and in section 45 directs the Revisor to make the terminology change in other subdivisions, House amends the entire section, and makes the terminology changes throughout the section.  Senate requires the commissioner to “continue and expand” the project. Senate effective date is 1-1-18; House 7-7-17. Also technical differences in (b)(3) and (6) – staff recommend Senate, and (11) – staff recommend House. Technical difference in (d)(5) – staff recommend Senate. | Sec. 26. Integrated health partnership demonstration project. Amends § 256B.0755. The amendments to subdivision 1 and throughout the section change the name of the health care delivery systems demonstration project to integrated health partnership demonstration project, and make related and conforming changes.  The amendment to subdivision 1, paragraph (b) requires the commissioner, in developing the request for proposals for integrated health partnerships, to allow these entities to be customized for the special needs and barriers of patients experiencing health disparities due to social, economic, racial, or ethnic factors.  The amendment to subdivision 3 requires accountability standards to be appropriate to the particular population served.  The amendment to subdivision 4 requires the payment system for integrated health partnerships to include a population-based payment that supports care coordination services, and is risk-adjusted to reflect variations in the intensiveness of care coordination for enrollees with chronic conditions, limited English skills, cultural differences, and other barriers to health care. Requires this payment to be a per member per month payment that is paid at least quarterly. Requires integrated health partnerships to continue to meet cost and quality metrics for the program, in order to maintain eligibility for the population-based payment. Provides that an integrated health partnership is eligible to receive a payment under this paragraph even if it is not participating in a risk-based or gain-sharing payment model and regardless of the size of the patient population served. States that an integrated health partnership certified as a health care home, that agrees to a payment method that includes population-based payments for care coordination, is not eligible to receive health care home payments, care coordination fees, or payments for in-reach community-based service coordination, for MA or MinnesotaCare recipients enrolled in, or attributed to, the integrated health partnership. |
| **Section 26 (256B.0755, subdivision 3)** specifies that the accountability standards for IHPs must be appropriate to the particular population served. | House subd. 3 is identical |  |
| **Section 27 (256B.0755, subdivision 4)** specifies that the payment system for IHPs must include a population-based payment that supports care coordination services for enrollees served by the IHP and is risk adjusted to reflect varying levels of care coordination intensiveness.  Specifies that the payment must be a per-member per-month payment paid at least on a quarterly basis and specifies that IHPs that receive this payment must continue to meet cost and quality metrics in order to maintain eligibility for the population-based payment. | Senate refers to risk-adjustment for cultural differences; House for persons who are homeless or experience health disparities. Differences in chapter 62U citation—Senate citation is correct. Senate effective date is 1-1-18; House 7-1-17. |  |
| **Section 28 (256B.0755, subdivision 9)** states that the commissioner may authorize an IHP to provide financial incentives for patients to see a primary care provider for an initial health assessment; maintain a continuous relationship with a primary care provider; and participate in ongoing health improvement and coordination of care activities. | Senate-only provision. |  |
|  | House-only provision | Sec. 27. Health care delivery systems demonstration project. Adds § 256B.0759.  Subd. 1. Implementation. (a) Requires the commissioner to develop and implement a demonstration project to test delivery system payment and care models that provide services to MA and MinnesotaCare enrollees based on prospective per capita or total cost of care payments. Requires the project to be implemented in coordination with, and as an expansion of, the integrated health partnership demonstration project.  (b) Specifies criteria for the commissioner to follow in developing the project.  Subd. 2. Requirements for health care delivery systems. (a) Requires health care delivery systems to provide required services and care coordination, establish a process to monitor enrollment and ensure quality of care, coordinate service delivery with social services programs, provide a system for advocacy and consumer protection, and adopt innovative and cost-effective methods of care delivery and coordination.  (b) Specifies the types of health care providers that may establish a health care delivery system.  (c) Requires a health care delivery system to contract with a third-party administrator, specifies related criteria, and allows the commissioner to waive this requirement.  Subd. 3. Enrollment. (a) States that individuals eligible for MA or MinnesotaCare are eligible to enroll in a health care delivery system. Allows individuals to opt-out of prepaid MA or prepaid MinnesotaCare, and receive care through a health care delivery system.  (b) Allows individuals to enroll in a health care delivery system that serves the county in which they reside, and to have a choice between delivery systems if more than one delivery system serves the county. States that enrollment in a specific health care delivery system is for 12 months, except that persons who do not maintain eligibility shall be disenrolled and persons experiencing a qualifying life event may change delivery systems or opt out of the demonstration project.  (c) Specifies criteria governing assignment of individuals to a delivery system.  Subd. 4. Accountability. (a) States that health care delivery systems are responsible for quality of care, and enrollee cost of care and utilization. Requires the commissioner to adjust accountability standards to take into account various barriers to care experienced by a delivery system’s patient population.  (b) Requires a delivery system to contract with community health clinics, federally qualified health centers, and other specified entities, to the extent practicable.  (c) Specifies requirements for coordination of services with other providers, county agencies, and other local entities.  Subd. 5. Payment system. Requires the commissioner to develop a payment system for the project that includes prospective per capita payments, total cost of care benchmarks, and risk/gain sharing payment options. Also requires the payment system to include incentive payments related to quality and performance targets.  Subd. 6. Federal waiver or approval. Directs the commissioner to seek all federal waivers or approval necessary to implement the demonstration project, and to report to legislative committees on any federal action related to the request.  States that the section is effective January 1, 2018, or upon receipt of federal waivers or approval, whichever is later. |
| **Section 29 (256B.0924, subdivision 4a)** allows medical assistance reimbursement for interactive video contact for targeted case management for vulnerable adults and adults with developmental disabilities.  This section also sets the parameters for contact by interactive video for targeted case management.  Interactive video is subject to federal approval, and is allowed if the requirements are met. | Identical except for effective date. Senate provision is effective three months after federal approval; House 7-1-17. | Article 6, sec. 16. Targeted case management through interactive video. Amends § 256B.0924, by adding subd. 4a. Paragraph (a) provides, subject to federal approval, that medical assistance will pay for targeted case management services provided by interactive video to a person who resides in a hospital, nursing facility, or residential setting staffed 24 hours a day, seven days a week. Use of interactive video must be approved in the case plan, must be in the best interests of the person, and must be approved by the person receiving services, the case manager, and the provider operating the setting where the person resides. Provides that interactive video cannot be used for more than 50 percent of the minimum required face-to-face contacts.  Paragraph (b) allows the person receiving services the right to consent to use of interactive active and to refuse the use of interactive video at any time.  Paragraph (c) instructs the commissioner to establish criteria for providing targeted case management via interactive video, and lists possible criteria addressing client safety, policies and protocols, and quality assurance.  Paragraph (d) provides the documentation requirements for a targeted case management provider to receive medical assistance reimbursement for services provided by interactive video. |
|  |  | Sec. 28 is compared in the comparison summary of Senate article 8/House article 6. |
|  |  | **Sec. 29** is compared in the comparison summary of Senate article 8/House article 6. |
|  |  | **Sec. 30** is compared in the comparison summary of Senate article 8/House article 6. |
|  |  | **Sec. 31** is compared in the comparison summary of Senate article 8/House article 6. |
|  | House-only provision  (S.F. 216 is on Senate floor.) | Sec. 32. Policy and applicability. Amends § 256B.15, subd. 1, paragraph (c). Removes the beginning date from a MA definition.  Makes this section effective the day following final enactment, and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016. |
|  | House-only provision  (S.F. 216 is on Senate floor.) | Sec. 33. Estates subject to claims. Amends § 256B.15, subd. 1a. Strikes language allowing recovery from the estate of a person over 55 years of age for general MA services rendered before January 1, 2014. Limits estate recovery claims to the amount of MA paid on behalf of a person who resided in a medical institution, who received general assistance medical care (formerly under chapter 256D), or who received MA long-term services and supports at or after 55 years of age.  Makes section effective the day following final enactment and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016. |
|  | House-only provision  (S.F. 216 is on Senate floor.) | Sec. 34. Limitations on claims. Amends § 256B.15, subd. 2. Removes language allowing estate recovery for general MA services rendered before January 1, 2014. Specifies that an estate claim must only include: (1) the amount of medical assistance rendered to persons 55 or older for long-term services and supports; (2) the total amount of medical assistance rendered during a period of institutionalization; and (3) the total amount of general assistance medical care (formerly under chapter 256D). Clarifies that “home and community-based services” includes alternative care services, even when those services receive only state funding.  Makes section effective the day following final enactment and applicable retroactively to estate claims pending on or after July 1, 2016, and to estates of people who died on or after July 1, 2016. |
| **Section 30 (256B.196, subdivision 2)** phases out the “managed care intergovernmental transfer” over seven years by reducing the total value of supplemental payments to Hennepin County Medical Center and Regions Hospital by approximately $1,800,000 per year. | Senate phases-down an existing IGT that involves capitation payments; House does not.  House expands an IGT for ambulance services and also authorizes new IGTs involving University of Minnesota physician and dental services. | **Sec. 35. Commissioner’s duties.** Amends § 256B.192, subd. 2. The amendment to paragraph (d) allows ambulance services owned and operated by a governmental organization to participate in an existing intergovernmental transfer (IGT) arrangement for ambulance services that currently applies to ambulance services affiliated with Hennepin County Medical Center and the city of St. Paul. Requires the commissioner to determine an upper payment limit for these ambulance services, inform participating governmental entities of the IGTs necessary to match federal Medicaid payments available, and upon receipt of these transfers, to make supplementary payments to these entities equal to the difference between the MA payment rate and the upper payment limit. Provides that tribal governments that operate an ambulance service are not eligible to participate in the IGT arrangement for ambulance services.  A new paragraph (e) directs the commissioner to determine an upper payment limit for physicians, dentists, and other billing professionals affiliated with the University of Minnesota and University of Minnesota Physicians. Requires the commissioner to inform the University of Minnesota Medical School and School of Dentistry of the periodic intergovernmental transfers needed to match federal Medicaid payments available, in order to make supplemental payments to physicians, dentists, and other billing professionals equal to the difference between the established MA payment rate and the upper payment limit. Upon receipt of these transfers, requires the commissioner to make these supplemental payments.  A new paragraph (f) allows the University of Minnesota Medical School and School of Dentistry, beginning January 1, 2018, to make monthly voluntary intergovernmental transfers to the commissioner in amounts not to exceed $20 million per year from the medical school and $6 million per year from the school of dentistry. Directs the commissioner to increase MA capitation payments to any health plan under contract with MA that agrees to make enhanced payments to the University of Minnesota and the University of Minnesota Physicians, and specifies related requirements. Requires any health plan that receives increased capitation payments to increase its MA payments to the University of Minnesota and the University of Minnesota Physicians by the same amounts as the increased capitation payment received.  A new paragraph (i) states that all data and funding transactions are between the commissioner and the governmental entities.  States that paragraph (a) is effective July 1, 2017, or upon federal approval, whichever is later. |
|  | House-only provision | **Sec. 36. Intergovernmental transfers.** Amends § 256B.196, subd. 3. Requires all intergovernmental transfer payments made by the University of Minnesota Medical School and School of Dentistry to be used to match federal payments to the University of Minnesota and the University of Minnesota Physicians under subdivision 2, paragraphs (e) and (f). |
|  | House-only provision | **Sec. 37. Adjustments permitted.** Amends § 256B.196, subd. 4. Adds the average commercial rates for physician and other professional services to the list of factors for which the commissioner may adjust intergovernmental transfers and payments. Adds university schools to the list of entities that the commissioner must consult with prior to making adjustments. |
|  | House-only provision | Sec. 38. Managed care contracts. Amends § 256B.69, subd. 5a. For services provided on or after January 1, 2018, through December 31, 2018, requires the commissioner to withhold two percent of capitation payments for each MA enrollee. Requires the commissioner to return the withhold, between July 1 and July 31 of the following year, for capitation payments for enrollees for whom the managed care or county-based purchasing plan has submitted to the commissioner a verification of coverage form completed and signed by the enrollee. Specifies requirements for the form. Requires a plan to request all enrollees to complete the form, and requires the plan to submit all completed forms to the commissioner by February 28, 2018. If a completed form for an enrollee is not received by the commissioner by that date, requires the commissioner to not return funds withheld for that enrollee, cease making capitation payments for the enrollee, and disenroll the enrollee from MA, subject to enrollee appeal. |
| **Section 31 (256B.69, subdivision 9e)** modifies the current financial audit language for managed care organizations by adding a cross reference to section 3.972, subd. 2b. | Senate-only provision (conforming change to Senate section 1) |  |
|  | House-only provision (Senate section 42 creates a legislative commission on competitive bidding and procurement) | Sec. 39. Competitive bidding and procurement. Amends § 256B.69, by adding subd. 36.  (a) For managed care organization contracts effective on or after January 1, 2019, requires the commissioner to utilize a competitive price bidding program on a regional basis for nonelderly adults and children who are not eligible based on a disability and are enrolled in MA and MinnesotaCare. Requires the commissioner to establish geographic regions, and to not implement competitive bidding for more than 40 percent of the regions during each procurement. Requires the commissioner to ensure there is an adequate choice of managed care organizations, in a manner consistent with section 256B.694 (which allows sole-source contracting with county-based purchasing plans). Requires the commissioner to operate competitive bidding by region, but to award contracts by county and allow partial bids within a region based on counties served. Defines managed care organization.  (b) Requires the commissioner to provide the scoring weight of selection criteria in the request for proposals. Requires substantial weight to be given to county board resolutions and priority areas identified by counties.  (c) Requires that each responding managed care organization be given the opportunity to submit a best and final offer, if a best and final offer is requested.  (d) Requires the commissioner to consider network adequacy for dental and other services when evaluating proposals.  (e) Requires the commissioner to provide each managed care organization with its scoring sheet and other information and specifies related criteria.  (f) Allows a managed care organization to appeal the commissioner’s selection decision using a three-person mediation panel, but states that the panel recommendation is binding on the commissioner.  (g) Requires the commissioner to contract for an independent evaluation of the competitive bidding process. Requires the contractor to solicit recommendations for improving the competitive bidding process. Requires the commissioner to make evaluation results available on the department’s Web site. |
|  | House-only provision | Sec. 40. Hospital outpatient reimbursement. Amends § 256B.75. Specifies the method for determining outpatient payment rates for critical access hospitals. Requires Medicare cost report information to be used until DHS finalizes the MA cost reporting process for critical access hospitals. Specifies components of the outpatient rate. Provides a July 1, 2017, effective date. |
| **Section 32 (256B.76, subdivision 1)** reduces the payment rates by 2.3 percent for physician and professional services provided on or after July 1, 2017, through June 30, 2019, and by 3.0 percent for services provided on or after July 1, 2019. | Senate-only provision |  |
| **Section 33 (256B.76, subdivision 2)** increases payment rates for dental services provided on or after July 1, 2017, by 25 percent. | Senate-only provision |  |
| **Section 34 (256B.7635)** specifies for services provided on or after January 1, 2018, prenatal and postpartum follow-up home visits provide by public health nurses or registered nurses using evidence-based models. The payment shall be a minimum of $140 per visit. | Identical | Sec. 41. Reimbursement for evidence-based public health nurse home visits. Adds § 256B.7635. For services provided on or after January 1, 2018, sets MA payment rates for prenatal and post-partum follow-up home visits provided by a public health nurse, or a registered nurse supervised by a public health nurse, using evidence-based models, at a minimum of $140 per visit. Requires follow-up home visits to be administered by home visiting programs that meet specified criteria. Requires home visits to target mothers and their children beginning with prenatal visits through age three for the child. |
| **Section 35 (256B.766)** reduces the payment rates by 2.3 percent for basic care services provided on or after July 1, 2017, through June 30, 2019, and by 3.0 percent for services provided on or after July 1, 2019.  Specifies that EPSPT services are included in this reduction.  Specifies that the therapy services provided at Gillette Children’s Hospital are not included in this reduction. | Senate reduces payment rates; House does not.  House specifies the payment rate for ventilators; Senate does not.  Senate in (g) removes references to laboratory services for purposes of a 2015 rate increase to Gillette Hospital.  House in (i) specifies that categories of medical supplies may be individually priced.  Different effective dates. | Sec. 42. Reimbursement for basic health care services. Amends § 256B.766. Effective for items provided on or after January 1, 2016, sets the MA payment rate for non-pressure support ventilators at the lower of the submitted charge or the Medicare fee schedule rate, and sets the MA payment rate for pressure support ventilators at the lower of the submitted charge or 47 percent above the Medicare fee schedule rate. Provides a retroactive effective date of January 1, 2016. |
|  | House-only provision | Sec. 43. Definitions. Adds § 256B.90. Defines terms. |
|  | House-only provision | Sec. 44. Medical assistance outcomes-based payment program. Adds § 256B.91.  Subd. 1. Generally. Requires the commissioner to establish a hospital outcomes program to provide hospitals with information and incentives to reduce potentially avoidable events.  Subd. 2. Potentially avoidable event methodology. Requires the commissioner to select a methodology for identifying potentially avoidable events and associated costs, and for measuring hospital performance with respect to these events. Requires the commissioner to develop definitions for each potentially avoidable event. Requires the methodology, to the extent possible, to be one that has been used by other Medicaid programs or by commercial payers, and specifies other criteria.  Subd. 3. Medical assistance system waste. Requires the commissioner to analyze state databases to identify waste in the MA system. Requires the analysis to identify potentially avoidable events in MA and associated costs. Specifies related requirements. |
|  | House-only provision | Sec. 45. Hospital outcomes program. Adds § 256B.92.  Subd. 1. Generally. Requires the hospital outcomes program to: (1) target reduction of potentially avoidable readmissions and complications; (2) apply to all state acute care hospitals participating in MA; and (3) be implemented in two phases—performance reporting and outcomes-based financial incentives.  Subd. 2. Phase 1; performance reporting. Requires the commissioner to develop and maintain a reporting system to provide each hospital with reports on its performance for potentially avoidable readmissions and potentially avoidable complications. Specifies duties for the commissioner. Allows a hospital to share information in the outcome performance reports with health care providers to foster coordination and cooperation in the hospital’s outcome improvement and waste reduction initiatives.  Subd. 3. Phase 2; outcomes-based financial incentives. Requires the commissioner, 12 months after implementation of performance reporting, to establish financial incentives for a hospital to reduce potentially avoidable readmissions and potentially avoidable complications.  Subd. 4. Rate adjustment methodology. Requires the commissioner to adjust hospital reimbursement based on the hospital’s performance on outcome results. Specifies criteria for the rate methodology.  Subd. 5. Amendment of contracts. Requires the commissioner to amend hospital contracts as necessary to incorporate the financial incentives.  Subd. 6. Budget neutrality. Requires the program to be implemented in a budget-neutral manner for aggregate Medicaid hospital expenditures. |
| **Section 36 (256L.03, subdivision 1)** clarifies that a child means an individual younger than 19 years of age. | Senate-only provision |  |
| **Section 37 (256L.03, subdivision 1a)** removes coverage for individualized education program (IEP) services from MinnesotaCare coverage. | Senate-only provision |  |
| **Section 38 (256L.03, subdivision 5)** updates the cost-sharing by removing references in place prior to 2015, expands the definition to include co-insurance and deductibles, and replaces a reference that exempts American Indians from cost-sharing. | Senate-only provision |  |
| **Section 39 (256L.15, subdivision 2)** replaces the premium table to reflect the legislative changes enacted in 2015. | Senate updates the MinnesotaCare premium table to reflect earlier legislative changes; House increases premiums October 1, 2017. | Sec. 46. Sliding fee scale; monthly individual or family income. Amends § 256L.15, subd. 2. Effective October 1, 2017, increases premiums for MinnesotaCare enrollees. Current MinnesotaCare premiums range between $4 and $80 depending upon income, for persons who are not exempt. Under the new premium scale, premiums will range between $5 and $85. |
|  | House-only provision  (S.F. 341 passed Senate floor – identical.) | Sec. 47. Payment of expenses. Amends Laws 1988, chapter 645, section 3, as amended. Allows a portion of the tax levied by a hospital district to be used for administrative, operation, or salary expenses for the Cook ambulance service and the Orr ambulance service. Provides an immediate effective date. |
| **Section 40** delays part of the capitation payment to managed care plans and county-based purchasing plans due in April 2019, and all of the payment due in May 2019, and the payment due in April 2019 for special needs basic care until July 1, 2019.  This section also delays the capitation payment due in April 2021 and May 2021 and the payment due in April 2021 for special needs basic care until July 1, 2021. | House and Senate both delay a month of capitation payment. Senate in addition delays a portion of an additional month’s payment.   * Senate delays a portion of the MA capitation payment for April 2019 and all of the May 2019 payment, and the April 2019 payment for special needs basic care. House delays the MA and MinnesotaCare capitation payment due in May 2019, and the April 2019 payment for special needs basic care. * Senate delays the MA capitation payment for April and May 2021, and the April 2021 payment for special needs basic care. House delays the MA and MinnesotaCare capitation payment due in the second quarter of CY 2021 and the April 2021 payment for special needs basic care. | **Sec. 48. Capitation payment delay.** (a) Requires the commissioner of human services to delay $135 million of MA and MinnesotaCare capitation payments to managed care and county-based purchasing plans due in May 2019 and the special needs basic care payment due in April 2019, until July 1, 2019. Requires payment to be made between July 1, 2019, and July 31, 2019.  (b) Requires the commissioner of human services to delay $135 million of MA and MinnesotaCare capitation payments to managed care and county-based purchasing plans due in the second quarter of calendar year 2021 and the special needs basic care payment due in April 2021, until July 1, 2021. Requires payment to be made between July 1, 2021, and July 31, 2021. |
| **Section 41** requires the Commissioner of Human Services to seek federal approval to implement case management via interactive video contact. | Senate requires federal approval for § 256B.0924, subd. 4a; House does not. Senate requires federal approval for section 256B.0625, subd. 20b and House for subd. 20. Otherwise identical. | Article 6, sec. 20. Commissioner duty to seek federal approval. Instructs the commissioner to seek federal approval necessary to implement the provisions related to interactive video case management. |
| **Section 42** establishes a legislative commission to study and make recommendations on issues relating to the competitive bidding process and procurement process for the medical assistance and MinnesotaCare contracts with managed care plans and county-based purchasing plans for nonelderly, nondisabled adults and children.  The study shall also include recommendations of a process that meets federal regulations that ensures that provider rate increases passed by the legislature are incorporated into capitation rates paid to managed care organizations and how the managed care organizations pay the providers. | Senate-only provision |  |
| **Section 43 (Health Care Access Fund Assessment)** requires the Commissioner of Human Services to assess any federal health care reform legislation passed at the federal level on its effect on the MinnesotaCare program and the need for the health care access fund as its continued source of funding. | Senate-only provision |  |
| **Section 44 (Opiate Use and Acupuncture Study)** requires the Human Services Policy Committee to study and compare the use of opiates for the treatment of chronic pain conditions when acupuncture services are also part of the treatment for chronic pain. | Senate-only provision |  |
|  | House-only provision | Sec. 49 is compared in the comparison summary of Senate article 8/House article 6. |
|  | House-only provision | Sec. 50. Encounter reporting of 340B eligible drugs. (a) By January 1, 2018, requires the Commissioner of Human Services, in consultation with specified entities, to develop a process to identify and report at point of sale 340B drugs dispensed to enrollees of managed care organizations who are patients of an FQHC, in order to exclude these claims from the Medicaid drug rebate program. Requires the commissioner to ensure that FQHCs are allowed to utilize 340B drug discounts if a FQHC utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program, and to also ensure that duplicate discounts for drugs do not occur.  (b) Requires the commissioner, by January 1, 2018, to notify the chairs and ranking minority members of the legislative committees with jurisdiction over MA when the process required by paragraph (a) was developed, or to report why the process was not developed. |
|  | House-only provision | Sec. 51. Rate-setting analysis report. Requires the commissioner of human services to analyze and report on the current rate-setting methodology for outpatient, professional, and physician services that do not have a cost-based, federally mandated, or contracted rate. Requires the report to include recommendations for changes to the existing Resource-Based Relative Value System fee schedule, and alternative payment methodologies for services that do not have relative values, to simplify the rate structure and improve consistency and transparency. Requires the commissioner to consult with outside experts in Medicaid financing when developing the report. Requires the commissioner to report the analysis to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services finance by November 1, 2019. |
|  | House-only provision | Sec. 52. Study of payment rates for durable medical equipment and supplies. Requires the commissioner of human services to study the impact of basing MA payment for durable medical equipment and supplies on Medicare payments, as limited by the federal 21st Century Cures Act, on access by MA enrollees to these items. Requires the study to include recommendations for ensuring and improving access by MA enrollees to durable medical equipment and supplies. Requires the commissioner to report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance, by February 1, 2018. |
|  | House-only provision | Sec. 53. Federal approval. Requires the commissioner of human services to request any federal waivers and approvals necessary to allow the state to retain federal funds accruing in the state’s basic health program trust fund, and expend those funds for purposes other than those specified in federal law. (In general, federal law requires the trust funds to be used only to reduce premiums and cost-sharing or provide additional benefits to eligible individuals.) Requires the commissioner to report any federal action regarding the request to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance. Provides an immediate effective date. |
|  | House-only provision (conforming change to House section 25) | Sec. 54. Federal waiver or approval. Requires the commissioner to seek any federal waiver or approval necessary to implement section 256B.0644. |
| **Section 45** is a Revisor’s instruction requiring the Revisor to change the term “health care delivery system” to “integrated health partnership” where it appears in section 256B.0755. | Senate-only provision |  |
| **Section 46 (Repealer)** repeals the annual review for personal care assistance provider agencies, the home care nursing interpreter-communicator service, and IGT2. | Senate-only provision |  |