Bill Comparison Summary of
Senate File 4410 (second unofficial engrossment) / Senate File 4410 (third engrossment)

House Article 3: Health Care Finance
Senate Article 3: Health Care

Prepared by:

House Research Department and Senate Counsel, Research and Fiscal Analysis

May 6, 2022

Comparison Summary of S.F. 4410 – House (S.F. 4410, second unofficial engrossment) / Senate (4410, third engrossment)

Section	HOUSE **Article 3: Health Care Finance**		SENATE **Article 3: Health Care**
1	**Definitions.** Adds § 62J.86. Defines "advisory council" and "board."	House only	
2	**Health Care Affordability Board.** Adds § 62J.87. **Subd. 1. Establishment.** States that the Health Care Affordability Board is established and shall be governed as a board to protect consumers, the government, health plan companies, providers, and other health care system stakeholders from unaffordable health care costs. Requires the board to be operational by January 1, 2023. **Subd. 2. Membership.** (a) Provides that the board consists of 13 members, appointed as specified by the governor and the legislature. (b) Requires board members to have knowledge and demonstrated expertise in one or more specified areas of health care. (c) Prohibits board members from participating in board proceedings in which the member has a direct or indirect financial interest, other than as an individual consumer of health care services. (d) Requires the LCC to coordinate appointments to ensure that board members are appointed by August 1, 2022, and the requirements related to knowledge and expertise are met.	House only	

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	Subd. 3. Terms. Specifies term lengths and related requirements. **Subd. 4. Chair; other officers.** Requires the governor to designate an acting chair from among the governor's appointments, with the board to elect a chair at the first meeting. Specifies related requirements. **Subd. 5. Staff; technical assistance; contracting.** (a) Requires MDH to provide an executive director and staff. (b) Requires the attorney general to provide legal services to the board. (c) Requires MDH to provide technical assistance to the board in analyzing health care trends and costs and setting health care spending growth targets. (d) Allows the board to employ or contract for professional and technical assistance, including actuarial assistance. **Subd. 6. Access to information.** (a) Allows the board to request and receive publicly available information from state agencies, at no cost. (b) Allows the board to request and receive from state agencies unique or custom data sets, and be charged the rate that applies to any public or private entity. (c) Requires information provided to the board by a state agency to be de-identified.		

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	(d) States that any data provided to the board retains their original classification under the Data Practices Act. **Subd. 7. Compensation.** Provides that board members do not receive compensation but may be reimbursed for expenses. **Subd. 8. Meetings.** States the board meetings are subject to the Open Meeting Law. Requires the board to meet publicly at least quarterly and specifies related criteria.		
3	**Health Care Affordability Advisory Council.** Adds § 62J.88. Requires the governor to appoint a Health Care Affordability Advisory Council to advise the board on health care cost and access issues and represent the views of patients and other stakeholders. Specifies requirements for board members and for advisory council duties, terms, compensation, and meetings. Provides that the council does not expire.	House only	
4	**Duties of the board.** Adds § 62J.89. **Subd. 1. General.** (a) Directs the board to monitor the administration and reform of health care delivery and payments systems in the state. Requires the board to: 1) set health care spending and growth targets for the state; 2) enhance provider organization transparency; 3) monitor the adoption and effectiveness of alternative payment methodologies;	House only	

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	4) foster innovative health care delivery and payment models; 5) monitor and review the impact of health care marketplace changes; and 6) monitor patient access to necessary health care services. (b) Requires the board to establish goals to reduce health care disparities and ensure access to quality care for persons with disabilities or chronic or complex health conditions. **Subd. 2. Market trends.** Requires the board to monitor efforts to reform the health care delivery and payment system in the state to understand emerging trends in the commercial and large self-insured markets, and state public health care programs, in order to identify opportunities for the state to achieve: 1) improved patient experience of care, including quality and satisfaction; 2) improved health of all populations, including a reduction in health disparities; and 3) a reduction in the growth of health care costs. **Subd. 3. Recommendations for reform.** Requires the board to make recommendations for legislative policy, market, or other reforms to: 1) lower the rate of growth in commercial health care costs and public health care program spending;		

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	2) positively impact the state rankings in the areas listed in this subdivision and subdivision 2; and 3) improve the quality and value of care for all Minnesotans, and for specific populations adversely affected by health inequities. **Subd. 4. Office of Patient Protection.** Requires the board to establish an Office of Patient Protection, to be operational by January 1, 2024. Requires the office to assist consumers with issues related to access and quality of care, and advise the legislature on ways to reduce consumer health care spending and improve consumer experience by reducing complexity for consumers.		
5	**Health care spending growth targets.** Adds § 62J.90. **Subd. 1. Establishment and administration.** Requires the board to establish and administer the health care spending growth target program to limit health care spending in the state, and requires the board to report regularly to the legislature and public on progress toward these targets. **Subd. 2. Methodology.** (a) Requires the board to develop a methodology to establish annual health care spending growth targets and the economic indicators to be used in establishing the initial and subsequent target levels. (b) Requires the health care spending growth target to: 1) use a clear and operational definition of total state health care spending;	House only	

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	2) promote a predictable and sustainable rate of growth for total health care spending, measured by an established economic indicator such as the rate of increase of the state's economy or personal income, or a combination; 3) defines the health care markets and the entities to which the targets apply; 4) take into consideration the potential for variability in targets across public and private payers; 5) account for patient health status; and 6) incorporate health equity benchmarks. (c) Requires the board, in developing, implementing, and evaluating the growth target program, to: 1) consider the incorporation of quality of care and primary health care spending goals; 2) ensure the program does not place a disproportionate burden on communities most impacted by health disparities, the providers serving these communities, and individuals who reside in rural areas or have high health care needs; 3) consider payment models that ensure financial sustainability of rural health care delivery systems and the ability to provide population health; 4) allow for setting growth targets that encourage health care entities to serve populations with greater health care risks, by incorporating risk adjustment and equity adjustment;		

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	5) ensure that growth targets do not constrain the Minnesota workforce, do not limit the use of collective bargaining or set a floor or ceiling on compensation, and promote workforce stability and the maintenance of high-quality jobs; and 6) consult with the advisory council and other stakeholders. **Subd. 3. Data.** Requires the board to identify necessary data and methods of data collection, and specifies criteria. **Subd. 4. Setting growth targets; related duties.** (a) Requires the board, by June 15, 2023, and by June 15 of each succeeding calendar year through June 15, 2027, to establish annual health care spending growth targets for the next calendar year. Requires annual targets to be set for the five-year period from January 1, 2024, through December 31, 2028. (b) Requires the board to periodically review growth target program methodology, economic indicators, and other factors, and allows the board to revise annual growth targets after a public hearing. If the board revises a growth target, requires the board to provide public notice at least 60 days before the start of the calendar year to which the revised target will apply. (c) Requires the board, based on an analysis of drivers of health care spending and public testimony, to evaluate strategies and new policies that can contribute toward meeting health care growth targets and limiting spending growth, without increasing disparities in access.		

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	Subd. 5. Hearings. Requires the board to hold hearings, at least annually, to present findings from growth target monitoring. Requires the board to hold regular public hearings as needed to perform its duties, and to take stakeholder testimony on health care spending growth, setting and revising growth targets, and the impact of spending growth and growth targets on health care access and quality.		
6	**Notice to health care entities.** Adds § 62J.91. **Subd. 1. Notice.** (a) Requires the board to notify all health care entities that have been identified by the board as exceeding the spending growth target for any given year. (b) States that "health care entity" shall be defined by the board. Provides a definition of this term that the board must consider. **Subd. 2. Performance improvement plans.** (a) States that the board must require some or all entities provided notice that they have exceeded the growth target to file and implement a performance improvement plan. Requires the board to provide the entities with written notice of this requirement. (b) Requires the entity, within 45 days of receiving notice, to either file a performance improvement plan, or file an application to waive the requirement or extend the timeline for filing the plan.	House only	

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	(c) Specifies the process and requirements for filing an application to waive or extend the timeline for filing a performance improvement plan. (d) Specifies the timeline for filing a performance improvement plan and requirements for the plan. These plan requirements include specific identifiable and measurable expected outcomes and a timetable for implementation that must not exceed 18 months. (e) Specifies the process the board must follow in approving a performance improvement plan or determining the plan is unacceptable or incomplete. (f) Requires health care entities to work to implement the performance improvement plan in good faith, and allows entities to file amendments to the plan for board approval. If the entity does not successfully complete the plan, directs the board to: (1) extend the implementation timetable of the existing plan; (2) approve amendments to the plan; (3) require a new performance plan; or (4) waive or delay the requirement to file any additional plans. If the entity successfully completes the performance plan, requires the board to remove the identity of the entity from the board's website. Allows the board to assist entities in implementing performance plans or otherwise ensure compliance with this subdivision. (g) Allows the board to assess to a health care entity a civil penalty of not more than $50,000 as a last resort, if the board determines the entity has: (1) willfully neglected to file a performance plan within the timeline; (2) failed to file an acceptable plan in good faith; (3) failed to implement		

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	the performance plan in good faith; or (4) knowingly filed to provide required information, or knowingly provided false information.		
7	**Reporting requirements.** Adds § 62J.92. **Subd. 1. General requirement.** Requires the board to present the reports required by this section to specified legislative committees, and to make these reports available to the public. Allows the board to contract with a third-party vendor for technical assistance in preparing the reports. **Subd. 2. Progress reports.** Requires the board to submit progress reports on the development and implementation of the health care spending growth target program by February 15, 2024, and February 15, 2025. Specifies requirements for these reports. **Subd. 3. Health care spending trends.** Requires the board to report, by December 15, 2024, and every December 15 thereafter, a report on health care spending trends and the health care spending growth target program. Specifies information that must be included in the reports.	House only	
8	**Restricted uses of the all-payer claims data.** Amends § 62U.04, subd. 11. Allows the commissioner of health or the commissioner's designee to use the all-payer claims database to provide technical assistance to the Health Care Affordability Board.	House only	

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9	**Education on contraceptive options.** Amends § 256.01, by adding subd. 43. Requires the commissioner to require hospitals and relevant primary care providers serving MA and MinnesotaCare enrollees to develop and implement protocols to provide these enrollees with information on the full range of contraceptive options. Requires this to be done in a medically ethical, culturally competent, and noncoercive manner. Specifies related requirements. Requires hospitals and providers to make the protocols available to the commissioner upon request.	House only	
10	**Long-acting reversible contraceptives.** Amends § 256.969, by adding subd. 31. (a) Requires the commissioner to provide separate reimbursement to hospitals for long-acting reversible contraceptives provided immediately postpartum in the hospital setting. States that this payment must be in addition to diagnostic related group reimbursement for labor and delivery. (b) Directs the commissioner to require managed care and county-based purchasing plans to comply with this subdivision when providing services to MA enrollees. States that this section is effective January 1, 2023.	House only	
11	**Projects.** Amends § 256B.021, subd. 4. Makes a conforming change, removing a reference to MA and MinnesotaCare cost-sharing. Provides a January 1, 2023, effective date.	House only	

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12	**Dental utilization report.** Amends § 256B.0371, subd. 4. Requires the annual DHS reports to the legislature on dental utilization to include, beginning with the report due March 15, 2023, the following information on dental provider enrollment: 1) the number of dentists enrolled as MA dental providers and the congressional districts each dentist serves; 2) the number of enrolled dentists who provided services under fee-for-service within the previous coverage year and the number of patients in specified increments; 3) the number of enrolled dentists who provided services through a managed care or county-based purchasing plan within the previous coverage year and the number of patients in specified increments; and 4) the number of dentists who provided services to a new patient enrolled in MA or MinnesotaCare within the previous coverage year. Requires the March 15, 2023, report to include the information listed above for each of the following years: 2017, 2018, 2019, 2020, and 2021.	Identical	**Section 2 (256B.0371, subd. 4)** requires that for the annual dental utilization report beginning in the report due March 15, 2023, the commissioner of human services is required to include certain information regarding the number of dentists enrolled as medical assistance providers and the number of enrolled dental providers who provide dental services to enrollees receiving services through the fee-for-service system and under managed care.
13	**Competitive bidding.** Amends § 256B.04, subd. 14. Makes a conforming change, removing a reference to MA and MinnesotaCare cost-sharing. Provides a January 1, 2023, effective date.	House only	

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14	**Competitive bidding.** Amends § 256B.04, subd. 14. Allows the commissioner to use volume purchase through competitive bidding and negotiation for quitline services. States that the section is effective January 1, 2023, or upon federal approval, whichever is later.	House only	
15	**Adults who were in foster care at the age of 18.** Amends § 256B.055, subd. 17. Allows MA to be paid, beginning January 1, 2023, for a person under age 26 who was in foster care and enrolled in another state's Medicaid program while in foster care, in accordance with specified federal law. States that the section is effective January 1, 2023.	House only	
16	**Asset limitations for certain individuals.** Amends § 256B.056, subd. 3. Increases the MA asset limit for persons who are age 65 and older or have disabilities, from $3,000 to $20,000 for a household of one and from $6,000 to $40,000 for a household of two. For individuals enrolled in MA during the COVID-19 federal public health emergency who are subject to asset limits, requires excess assets to be disregarded until 95 days after the individual's first renewal occurring after expiration of the COVID-19 public health emergency. States that the asset limit increase is effective January 1, 2025, or upon federal approval, whichever is later, and the asset disregard provision is effective July 1, 2022, or upon federal approval, whichever is later.	House only	
17	**Income.** Amends § 256B.056, subd. 4. Increases the MA income limit for persons with disabilities and persons age 65 or older from 100	House only	

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	percent of FPG to 133 percent of FPG effective January 1, 2025. The MA spenddown limit for these groups is also increased to this percentage of FPG. (The spenddown limit for these groups is currently 81 percent of FPG and is scheduled to increase to 100 percent of FPG effective July 1, 2022.)		
18	**Period of eligibility.** Amends § 256B.057, subd. 7. Allows a child under age 21, once determined eligible for MA, to be continuously eligible for the program for up to 12 months, unless: 1) the child reaches age 21; 2) the child requests voluntary termination of coverage; 3) the child ceases to be a Minnesota resident; 4) the child dies; or 5) the agency determines that eligibility was erroneously granted to the child due to agency error or enrollee fraud, abuse, or perjury. States that the section is effective January 1, 2024, or upon federal approval, whichever is later.	House only	
		Senate only	**Section 3 (256B.057, subd. 9),** paragraph (e) modifies the existing medical assistance premium schedule for employed people with disabilities by eliminating the minimum monthly payment of $35, establishing a revised sliding premium fee scale that begins at 0% of enrollee income below 200% of federal poverty guidelines and increases at varying rates to 7.5% of enrollee income greater than 500% of federal poverty guidelines. Under current law, the premium schedule is the greater of $35 or a sliding premium scale beginning at 1% of

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			income for enrollee incomes at 100% of federal poverty guidelines and increasing to 7.5% of income for enrollee incomes of 300% or greater of federal poverty guidelines.
19	**Dental services.** Amends § 256B.0625, subd. 9. The amendment to paragraph (a) states that MA covers medically necessary dental services, and strikes language that limits MA coverage of dental services for adults who are not pregnant to specific services. The amendment to paragraph (b) makes conforming changes and does not change coverage under current law. States that the section is effective January 1, 2023, or upon federal approval, whichever is later.	House only	
		Senate only	**Section 4 (256B.0625, subd. 10)** requires medical assistance to cover laboratory tests when ordered and performed by a licensed pharmacist and reimburse the pharmacist at no less than the rate for which the same services are reimbursed when provided by any other practitioner.
20	**Transportation costs.** Amends § 256B.0625, subd. 17. Requires the commissioner, effective the first day of each calendar quarter in which the price of gasoline exceeds $3.00 per gallon, to adjust the mileage rate paid to nonemergency medical transportation providers by one percent, up or down, for every increase or decrease of ten cents in the price of gasoline. Provides a July 1, 2022, effective date.	**Paragraph (m):** Senate increases the base rate and mileage rate; House does not. **Paragraph (r):** Identical (both House and Senate adjust rates based on the price of gasoline)	**Section 5 (256B.0625, subdivision 17, paragraph (m))** increases by 17.5 percent the base rate and the mileage rate for the following modes of non-emergency medical transportation: unassisted transport, assisted transport, and lift- or ramp-equipped transport. **Paragraph (r)** establishes a monthly fuel cost adjustor for NEMT reimbursement rates, pegged to $3.00 per gallon.

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21	**Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Requires the commissioner, effective the first day of each calendar quarter in which the price of gasoline exceeds $3.00 per gallon, to adjust the mileage rate paid to ambulance service providers by one percent, up or down, for every increase or decrease of ten cents in the price of gasoline. Provides a July 1, 2022, effective date.	Identical	**Section 6 (256B.0625, subdivision 17a)** establishes a monthly fuel cost adjustor for ambulance services reimbursement rates, pegged to $3.00 per gallon.
22	**Nonemergency medical transportation provisions related to managed care.** Amends § 256B.0625, subd. 18h. Requires managed care and county-based purchasing plans to provide a fuel adjustment for nonemergency medical transportation payment rates when the price of gasoline exceeds $3.00 per gallon.	House only	
23	**Hospice care.** Amends § 256B.0625, subd. 22. States that hospice respite and end-of-life care under subdivision 22a are not hospice services under MA.	House only	
24	**Residential hospice facility; hospice respite and end-of-life care for children.** Amends § 256B.0625, by adding subd. 22a. (a) Provides MA coverage for hospice respite and end-of-life care if the care is for recipients under age 21 who elect to receive hospice care from a licensed hospice provider that is a	House only	

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	residential hospice facility. States that hospice care services under subdivision 22 are not hospice respite or end-of-life care. (b) States that payment rates for services under this subdivision shall be 100 percent of the Medicare rate for continuous home care hospice services as published by the Centers for Medicare and Medicaid Services. Requires payment to be made from state funds, but directs the commissioner to seek federal financial participation for the payments. Requires payment to be made to the residential hospice facility and provides that these payments are not included in any limits or cap amount that applies to hospice services payments to the elected hospice services provider. (c) Provides that certification of the residential hospice facility by Medicare must not be a requirement for MA payment for hospice respite and end-of-life care under this subdivision. States that the section is effective January 1, 2023.		
25	**Doula services.** Amends § 256B.0625, subd. 28b. Requires the commissioner to enroll doula agencies and individual treating doulas in order to provide direct reimbursement. States that the section is effective January 1, 2024, or upon federal approval, whichever is later.	House only	
26	**Other clinic services.** Amends § 256B.0625, subd. 30. Effective July 1, 2022, allows an enrolled Indian Health Service facility or a Tribal health center operating under a 638 contract to elect to also enroll as a Tribal	House only	

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	FQHC, and provides that requirements that apply to FQHCs under this subdivision do not apply unless necessary to comply with federal regulations. Directs the commissioner to establish an alternative payment method for Tribal FQHCs that uses the same methods and rates applicable to a Tribal facility or health center that does not enroll as a Tribal FQHC.		
27	**Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Provides that MA covers seizure detection devices as durable medical equipment if the seizure detection device is medically appropriate and the recipient's health care provider has identified that the device would: (i) likely reduce bodily harm or death as a result of a seizure; or (ii) provide data to the provider necessary to appropriately diagnose or treat the health condition that causes the seizure activity. Also defines seizure detection device. States that the section is effective January 1, 2023, or upon federal approval, whichever is later.	House only	
		Senate only	**Section 7 (256B.0625, subd.39**) requires medical assistance to cover vaccines that are initiated, ordered, or administered by a licensed pharmacist and reimburse the pharmacist at no less than the rate for which the same services are covered when provided by any other practitioner.
28	**Tobacco and nicotine cessation.** Amends § 256B.0625, by adding subd. 68. (a) States that MA covers tobacco and nicotine cessation services, drugs to treat tobacco and nicotine addiction or dependence, and drugs to help individuals discontinue use of tobacco and nicotine	House only	

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	products. Provides that MA must cover these services and drugs consistent with evidence-based or evidence-informed best practices. (b) Requires MA to cover in-person individual and group tobacco and nicotine cessation education and counseling, if provided by a health care provider within scope of practice. Provides a partial list of providers who may provide these services. (c) Requires MA to cover telephone cessation counseling services provided through a quitline, and allows these services to be provided through audio-only communications. Allows the commissioner to use volume purchasing for quitline services. (d) Requires MA to cover all prescription and over-the-counter drugs approved by the Food and Drug Administration for cessation of tobacco and nicotine use or treatment of tobacco and nicotine dependence, that are part of a Medicaid rebate agreement. (e) Allows services to be provided by telemedicine. (f) Prohibits the commissioner from: 1) restricting or limiting the type, duration, or frequency of cessation services; 2) prohibiting the simultaneous use of multiple cessation services; 3) requiring counseling prior to or as a condition of receiving drugs;		

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	4) limiting pharmacotherapy drug dosage amounts or dosing frequency, or imposing duration limits; 5) prohibiting the simultaneous use of multiple drugs; 6) requiring or authorizing step therapy; or 7) requiring or using prior authorization or requiring a copayment or deductible. (g) Provides that the commissioner must require all participating entities under contract to comply with this subdivision when serving MA and MinnesotaCare enrollees. Defines "participating entity" as a health carrier, county-based purchasing plan, accountable care organization, county integrated health care delivery network pilot, a network of health care providers established to provide services under MA or MinnesotaCare, or any other entity that has entered into capitation or risk-based payment arrangement or is paid under a reimbursement methodology with financial incentives to reduce the total cost of care. States that the section is effective January 1, 2023, or upon federal approval, whichever is later.		
29	**Medical assistance co-payments.** Amends § 256B.0631. Prohibits the MA program from requiring deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing for services provided on or after January 1, 2023. Provides that existing cost-sharing requirements for MA apply only for services provided through December 31, 2022.	House only	

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30	**Limitation of choice; opportunity to opt out.** Amends § 256B.69, subd. 4. Requires the commissioner to provide all MA enrollees required to enroll in managed care with the opportunity to opt out, and receive care under fee-for-service. Also makes conforming changes. Provides a January 1, 2023, effective date.	House only	
31	**Medical education and research fund.** Amends § 256B.69, subd. 5c. If the federal waiver that allows federal financial participation in the medical education and research fund is not renewed, terminates an existing transfer of $21,714,000 each fiscal year to the fund and also terminates certain payments from the fund. Requires the state share of an existing transfer of $49,552,000 each fiscal year to the fund to be distributed according the alternative method specified in statute.	House only	
32	**Medicare special needs plans; medical assistance basic health care.** Amends § 256B.69, subd. 28. Makes a conforming change, in the section of law allowing persons with disabilities to opt out of MA managed care. Provides a January 1, 2023, effective date.	House only	
33	**Enrollee support system.** Amends § 256B.69, subd. 36. Requires the DHS enrollee support system to provide access to counseling on opting out of managed care. Provides a January 1, 2023, effective date.	House only	

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34	**In general.** Amends § 256B.692, subd. 1. Makes a conforming change, adding a reference to the opt-out provision in a section dealing with county-based purchasing plans. Provides a January 1, 2023, effective date.	House only	
35	**Information provided by commissioner.** Amends § 256B.6925, subd. 1. Makes a conforming change, adding a reference to the opt-out provision and removing a reference to mandatory enrollment, in a section dealing with information provided to enrollees.	House only	
36	**Information provided by commissioner.** Amends § 256B.6925, subd. 1. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date.	House only	
37	**Information provided by managed care organizations.** Amends § 256B.6925, subd. 2. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date.	House only	
38	**Rate development standards.** Amends § 256B.6928, subd. 3. Makes a conforming change, removing a reference to MA cost-sharing. Provides a January 1, 2023, effective date.	House only	

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39	**Physician reimbursement.** Amends § 256B.76, subd. 1. Allows MA to reimburse for the cost incurred to pay the Department of Health for metabolic testing of newborns who are MA recipients, when the sample is collected outside of an inpatient hospital or freestanding birth center (because the birth took place outside of these locations) or because it is not medically appropriate to collect the sample during the inpatient stay.	House only	
40	**Cost-sharing.** Amends § 256L.03, subd. 5. Prohibits the MinnesotaCare program from requiring deductibles, co-payments, coinsurance, or any other form of enrollee cost-sharing for services provided on or after January 1, 2023. Provides that existing MinnesotaCare requirements related to cost-sharing apply only for services provided through December 31, 2022.	House only	
41	**General requirements.** Amends § 256L.04, subd. 1c. Makes a conforming change related to the elimination of the MinnesotaCare income limit for persons eligible under the public option, by clarifying that persons eligible for MinnesotaCare with incomes less than or equal to 200 percent of FPG are not qualified individuals and therefore are not eligible to obtain coverage through MNsure (this section does not change the status of these individuals under current law). States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.	House only	

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42	**Ineligibility.** Amends § 256L.04, subd. 7a. Makes a conforming change, by exempting persons enrolled under the public option from a provision that prohibits adults from being enrolled in MinnesotaCare if their income is greater than the program income limit. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.	House only	
43	**Persons eligible for public option.** Amends § 256L.04, by adding subd. 15. Allows families and individuals with incomes above the MinnesotaCare income limit, who meet all other program eligibility requirements, to be eligible for MinnesotaCare. Allows enrollment of these individuals only during an annual open enrollment period or special enrollment period, as designated by MNsure. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.	House only	
44	**General requirements.** Amends § 256L.07, subd. 1. Makes a conforming change, by exempting persons whose income increases above 200 percent of FPG from MinnesotaCare disenrollment if they continue enrollment through the public option. States that the section is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.	House only	

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45	**Sliding fee scale; monthly individual or family income.** Amends § 256L.15, subd. 2. The amendment to paragraph (c) requires the commissioner to continue the lower premiums for MinnesotaCare enrollees (reflecting compliance with federal ARPA requirements) on an ongoing basis, without regard to any sunset of the ARPA requirements. Also makes conforming changes, by striking the premium scale listed in current law. (This premium sale is not currently applied, given that MinnesotaCare as part of federal compliance uses the lower premium scales required by ARPA for 2021 and 2022). A new paragraph (d) requires the commissioner to establish a sliding premium scale for persons eligible through the public option, to be effective January 1, 2025. Exempts persons 20 years of age or younger from these premiums. States that the section is effective January 1, 2023, except that the sliding premium scale for persons eligible for the public option is effective January 1, 2025, or upon federal approval, subject to certification that implementation will not result in the loss of basic health program funding.	House only	
46	**Grants for periodic data matching.** Amends Laws 2015, chapter 71, article 14, section 2, subdivision 5, as further amended. Maintains the general fund base for fiscal years 2020 and 2021 for grants to counties for costs related to periodic data matching.	House only	

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47	**Waivers and modifications; federal funding extensions.** Amends Laws 2020, First Special Session chapter 7, section 1, subd. 1, as further amended. Extends COVID-19 DHS waivers and modifications related to preserving health care coverage for MA and MinnesotaCare until the enrollee's first renewal following resumption of MA and MinnesotaCare renewals after the end of the federal COVID-19 public health emergency.	House only	
48	**Response to COVID-19 public health emergency.** Amends Laws 2021, First Special Session chapter 7, article 1, § 36. Prohibits the commissioner of human services from collecting unpaid MA-EPD and MinnesotaCare premiums until the enrollee's first renewal after the resumption of MA renewals following the end of the federal public health emergency. Allows periodic data matching to be suspended for up to 12 months following the resumption of MA and MinnesotaCare renewals after the end of the federal public health emergency. Directs the commissioner of human services to take necessary actions to comply with federal guidance related to the appropriate redetermination of MA enrollee eligibility following the end of the federal public health emergency and allows the commissioner to waive current Minnesota statutes to the minimum level necessary to achieve federal compliance. Requires the commissioner to report to the legislature on changes implemented within 90 days.	House only	
49	**Dental home pilot project.** **Subd. 1. Establishment; requirements.** (a) Requires the commissioner to establish a dental home pilot project, to	House only	

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	increase the access of MA and MinnesotaCare enrollees to dental care, and improve patient experience and oral health clinical outcomes. Specifies related requirements. (b) Requires the design and operation of the pilot project to be consistent with the recommendations made by the Dental Services Advisory Committee to the legislature. (c) Requires the commissioner to establish baseline requirements and performance measures for dental homes that address access and patient experience and oral health clinical outcomes. **Subd. 2. Project design and timeline.** (a) Requires the commissioner to issue a preliminary project description and a request for information, to obtain stakeholder feedback and input on specified project design issues. (b) Requires the commissioner to consider this feedback and input and issue a request for proposals for pilot project participation. (c) Requires the pilot project to be implemented by July 1, 2023, and to include initial testing and the collection and analysis of data, to evaluate whether the baseline requirements and performance measures are appropriate. Requires the commissioner, under this phase, to provide grants to individual providers and provider networks that are in addition to regular MA and MinnesotaCare payments. (d) Allows the pilot project to test and analyze value-based payments to providers, to determine whether varying		

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	provider payments based on performance measures is appropriate and effective. (e) Requires the commissioner to ensure provider diversity in selecting project participants. Specifies criteria for the commissioner to consider in selecting providers. (f) Requires the commissioner to regularly consult with stakeholders in designing and implementing the pilot project, and as relevant to continue to seek input on project design issues specified in paragraph (a). **Subd. 3. Reporting.** (a) Requires the commissioner, beginning February 15, 2023, and each February 15 thereafter for the duration of the project, to annually report to the legislature on the design, implementation, operation, and results of the demonstration project. (b) Requires the commissioner, within six months of the end of the project, to report on the results of the demonstration project to the legislature, and include recommendations on whether the demonstration project, or specific features of the project, should be extended to all MA and MinnesotaCare dental providers.		
50	**Small employer public option.** Requires the commissioner of human services, in consultation with representatives of small employers, to develop a small employer public option that allows employees of businesses with fewer than 50 employees to receive employer contributions towards MinnesotaCare. Requires the commissioner to present recommendations to the legislature,	House only	

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	by December 15, 2023. States that the section is effective the day following final enactment.		
51	**Transition to MinnesotaCare public option.** (a) Requires the commissioner of human services to continue to administer MinnesotaCare as a basic health program, and to seek federal waivers, approvals, and law changes as required. (b) Requires the commissioner to present an implementation plan for the MinnesotaCare public option to the legislature, by December 15, 2023. Requires the plan to include: 1) recommendations for any changes to the public option needed to receive federal funding; 2) recommendations for implementing any small employer public option in a manner that would allow any employee payments towards premiums to be pretax; 3) recommendations for ensuring sufficient provider participation in MinnesotaCare; 4) estimates of state costs; 5) a description of the proposed premium scale for persons eligible through the public option, including an analysis of the extent to which the premium scale: (i) ensures that premiums are affordable for persons enrolled under the public option; and (ii) avoids premium cliffs for persons transitioning to or enrolled under the public option; and 6) draft legislation necessary to implement the public option and plan recommendations.	House only	

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	States that the section is effective the day following final enactment.		
52	**Request for federal approval.** (a) Requires the commissioner of human services to seek any federal waivers, approvals, and law changes necessary to implement this act, including but not limited to those necessary to allow the state: (1) to continue to receive basic health program payments and other federal funding; and (2) to receive federal payments equal to the value of premium tax credits and cost-sharing reductions that MinnesotaCare enrollees with incomes greater than 200 percent of FPG would otherwise have received. (b) Requires the commissioner of human services to consult with the commissioner of commerce and the Board of Directors of MNsure in implementing this section, and allows the commissioner of human services to contract for technical and actuarial assistance. States that the section is effective the day following final enactment.	House only	
53	**Delivery reform analysis report.** Requires the commissioner of human services to present to the legislature, by January 15, 2024, a report comparing service delivery and payment models for MinnesotaCare and certain MA enrollees. Requires the current delivery model to be compared with at least two alternative models, which must include a state-based model in which the state bears insurance risk and may contract with a third-party administrator for	House only	

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	claims processing and plan administration. Specifies other report requirements.		
54	**Recommendations; Office of Patient Protection.** (a) Requires the commissioners of human services, health, and commerce, and the MNsure board, to present a report to the legislature by January 15, 2023, on the organization and duties of the Office of Patient Protection. Specifies the scope of recommendations. (b) Requires the commissioners and board to consult with specified stakeholders as they develop recommendations. (c) Allows the commissioners and board to contract with a third party to develop the report and recommendations.	House only	
55	**Repealer.** Repeals § 256B.063 (provision related to MA cost-sharing), effective January 1, 2023.	House only	
		Senate only	**Section 9 [DIRECTION TO THE COMMISSIONER OF HUMAN SERVICES; ENTERAL NUTRITION AND SUPPLIES]** prohibits the commissioner of human services from adjusting medical assistance rates paid for enteral nutrition and supplies from the effective date of this section through June 30, 2023.
		Senate only (See House Article 8, Section 25)	**Section 10 [TEMPORARY TELEPHONE-ONLY TELEHEALTH AUTHORIZATION]** permits telephone telehealth visits to satisfy the face-to-face requirement for reimbursements to a FQHC, RHC, Indian health service, tribal clinic, and CBHC for services that would otherwise be reimbursed if the service was provided

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			in person. This section is effective retroactively from July 1, 2021, until July 1, 2023, or the COVID federal public health emergency ends, whichever occurs first.
		Senate only	**Section 11 [NONEMERGENCY MEDICAL TRANSPORTATION SPENDING REQUIREMENTS]** requires that at least 80% of the marginal increase in revenue resulting from implementation of the nonemergency medical transportation base rate and mileage rate increases for unassisted transport, assisted transport, and lift- or ramp-equipped transport increases be used by NEMT providers to increase compensation-related costs for eligible employees, defines eligible employees and compensation-related costs, and requires a distribution plan posted in a location accessible to all employees.
		Senate only	**Section 12 [PRESCRIPTION DIGITAL THERAPEUTICS PILOT PROGRAM]** requires the commissioner of human services to allocate $8,091,000 in round three of the federal opioid response grant program to be used for a pilot program to explore the effectiveness of using FDA authorized prescription digital therapeutics for the treatment of substance use disorders within the medical assistance program.