HOUSE RESEARCH

Bill Summary

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Overview

This bill contains legislative provisions requested by the Department of Human Services in a wide range of health care policy areas, including but not limited to: therapy services, eligibility and premiums for American Indians, prescription drugs, ambulance and nonemergency medical transportation services, hospice services, durable medical equipment and supplies, disproportionate share hospital payments, MA provider enrollment, and managed care data reporting.

Article 1: Rehabilitation Technical

1 **Effective date.** Amends Laws 2010, First Special Session, chapter 1, article 16, section 8. Exempts physical therapy services provided through managed care from service thresholds.

2 **Effective date.** Amends Laws 2010, First Special Session, chapter 1, article 16, section 9. Exempts occupational therapy services provided through managed care from service thresholds.

3 **Effective date.** Amends Laws 2010, First Special Session, chapter 1, article 16, section 10. Exempts speech language pathology services provided through managed care from service thresholds.

Article 2: Personal Care Assistance Services

1 **Notice of service changes to recipients.** Amends § 256B.0659, subd. 30. Specifies the timeline for enrollees to appeal changes in personal care assistance services.

Article 3: Federal Poverty Guidelines

1 **Families with children income methodology.** Amends § 256B.056, subd. 1c. Provides that adjustments in MA income standards based on changes in the federal poverty guidelines shall not result in income standards that are lower than those in effect on July 1 of the preceding year.

2 **Annual income limits adjustment.** Amends § 256L.04, subd. 7b. Provides that adjustments in MinnesotaCare income standards based on changes in the federal poverty guidelines shall not result in income standards that are lower than those in effect on July 1 of the preceding year.

Article 4: Clarification of American Indian language in ARRA

1 **Asset limitations for individuals and families.** Amends § 256B.056, subd. 3. Effective July 1, 2009, excludes from the MA asset limit for persons who are aged, blind, or disabled certain assets owned by American Indians, as required by section 5006 of the American Recovery and Reinvestment Act (ARRA).

2 **Asset limitations for families and children.** Amends § 256B.056, subd. 3c. Effective July 1, 2009, excludes from the MA asset limit for parents in families certain assets owned by American Indians, as required by section 5006 of the American Recovery and Reinvestment Act (ARRA).

3 **Employed persons with disabilities.** Amends § 256B.057, subd. 9. Effective July 1, 2009, exempts American Indians from paying premiums under the MA for employed persons with disabilities program, required by section 5006 of the American Recovery and Reinvestment Act (ARRA).

4 **Effective date of coverage.** Amends § 256L.05, subd. 3. Makes a conforming change related to the exemption for American Indians from MinnesotaCare premiums.

5 **Premium determination.** Amends § 256L.15, subd. 1. Effective July 1, 2009, requires the commissioner to waive MinnesotaCare premiums for American Indians as required by section 5006 of the American Recovery and Reinvestment Act (ARRA). Requires individuals to document status as an American Indian in order to qualify for the premium exemption.

6 **Repealer.** Repeals § 256.01, subd. 18b. (General language requiring the commissioner of human services to comply with the requirements in section 5006 of the ARRA related to American Indians).

Article 5: Active Pharmaceutical Ingredients

1 **Drugs.** Amends § 256B.0625, subd. 13. Specifies the circumstances under which MA covers selected active pharmaceutical ingredients and excipients used in compounded prescriptions. Also defines active pharmaceutical ingredient and excipient and requires the commissioner to establish a list of these ingredients included in the MA formulary.

2 **Drug formulary.** Amends § 256B.0625, subd. 13d. Adds references to active pharmaceutical ingredients to a section of law specifying the circumstances under which drugs are excluded from the MA formulary.

Article 6: Minimum Quantity of Over-the-Counter Drugs

1 **Drugs.** Amends § 256B.0625, subd. 13. Requires over-the-counter drugs to be dispensed in a quantity that is the lower of: (1) the number of dosage units contained in the manufacturer's original package; or (2) the number of dosage units required to complete the patient's course of therapy.

2 **Payment rates.** Amends § 256B.0625, subd. 13e. Strikes language requiring over-the-counter medications to be dispensed in the manufacturer's unopened package.

Article 7: Ambulance Reimbursement

1 **Payment for ambulance services.** Amends § 256B.0625, subd. 17a. Requires providers to bill for ambulance services using diagnosis codes, and requires these codes to be updated monthly and made available on the DHS website. (Current law requires providers to bill using Medicare criteria.)

Article 8: Hospice Age

1 **Hospice care.** Amends § 256B.0625, subd. 22. Lowers from 21 to 20 the age below which a recipient of MA hospice services does not waive coverage for treatment of the condition for which a diagnosis of terminal illness has been made.

Article 9: Durable Medical Equipment Definition and Accreditation for Suppliers

1 **Medical supplies and equipment.** Amends § 256B.0625, subd. 31. Requires vendors of durable medical equipment, prosthetics, orthotics, or medical supplies to enroll as Medicare providers. Allows the commissioner to exempt certain small-volume vendors from this requirement and also a vender that primarily serves pediatric patients and meets other criteria. Defines durable medical equipment.

Article 10: Eliminate Elderly Waiver Payment

1 **Prospective per capita payment.** Amends § 256B.69, subd. 5c. Eliminates the one-month capitation payment delay for elderly waiver payments.

Article 11: Special Needs Basic Care Medicaid Services

1 **Medicare special needs plans; medical assistance basic care.** Amends § 256B.69, subd. 28. Provides that the commissioner may contract with demonstration providers and current or former sponsors of qualified Medicare-approved special needs plans to provide MA basic health care services to persons with disabilities and to persons eligible for both Medicaid and Medicare.

Article 12: Health Services Advisory Council

1 **Revisor's instruction.** Directs the revisor to change the term "Health Services Policy Committee" to "Health Services Advisory Council" wherever it appears in statute.

Article 13: Disproportionate Share Hospital Payments under MinnesotaCare

1 **Payments reported by governmental entities.** Amends § 256B.199. Requires the commissioner, for MinnesotaCare hospital services provided on or after July 1, 2011, to apply for additional federal matching funds available as disproportionate share hospital payments.

2 **Enrollees 18 or older.** Amends § 256L.11, subd. 6. Provides that hospital admissions for

MinnesotaCare adults without children paid directly by the commissioner do not include chemical dependency hospital-based and residential treatment.

Article 14: Medical Assistance Providers

1 **Termination; terminate.** Amends § 256B.02, by adding subd. 16. Defines "termination" and "terminate" for purposes of providers under the Medicaid and state children's health insurance programs.

2 **Prohibition on payments to providers outside of the United States.** Amends § 256B.03, by adding subd. 4. Prohibits MA payments for services delivered or items supplied outside of the U.S., and to providers, financial institutions, or entities located outside of the U.S.

3 **Ordering or referring providers.** Amends § 256B.03, by adding subd. 5. Requires claims for payments for supplies or services that are based on an order or referral to include the ordering or referring provider's national provider identifier. States that claims ordered or referred by a vendor who is not enrolled in MA are not covered.

4 **Provider enrollment.** Amends § 256B.04, by adding subd. 20. Allows the commissioner to manage provider enrollment and payments by: withholding payment upon initial enrollment for a 90-day payment if there is a significant risk of fraudulent activity, requiring providers to establish compliance programs as a condition of enrollment, terminating enrollment if a provider fails to maintain and provide access to documentation, and terminating a provider if the provider has been terminated by Medicare or another state health care program. Also lists other requirements for providers seeking to enroll as MA providers, including but not limited to disclosing ties with other providers against whom action has been taken, allowing unannounced on-site inspections, and consenting to criminal background checks. Allows the commissioner to terminate enrollment for false statements, omissions, and misrepresentations, and to impose civil monetary penalties for this misconduct. Allows providers who are excluded, terminated, or subjected to a penalty to request a contested case proceeding.

5 **Imposition of monetary recovery and sanctions.** Amends § 256B.064, subd. 2. Modifies criteria and procedures used by the commissioner to seek monetary recoveries from and sanction vendors of medical care.

6 **Recovery procedures; sources.** Amends § 256B.0641, subd. 1. Allows the commissioner, in order to collect past due obligations, to adjust payments to a provider or vendor that has the same tax I.D. number as the provider or vendor with the past due obligation.

7 **Access to medical records.** Amends § 256B.27, subd. 3. Eliminates a requirement that a vendor of medical care receive at least 24 hours notice from the commissioner of the need to access personal medical records of MA recipients for purposes of investigating claims for reimbursement or determining whether care was medically necessary.

Article 15: Nonemergency Medical Transportation

1 **Nonemergency medical transportation advisory committee.** Requires the commissioner to establish a nonemergency medical transportation advisory committee to advise the commissioner on creating a single administrative structure for the coordination and management of nonemergency medical transportation services. Specifies membership and requires the commissioner to submit a proposal with draft legislation to the legislature by January 15, 2012.

Article 16: Managed Care Reporting

1 **Managed care plans.** Amends § 13.461, subd. 24a. Eliminates and adds cross-references in a section related to the classification of data provided by managed care plans.

2 **Managed care financial reporting.** Amends § 256B.69, by adding subd. 9c. (a) Requires the commissioner to collect detailed data on financials, provider payments, provider rate methodologies, and other data. Requires the commissioner, in consultations with the commissioners of health and commerce, to set uniform criteria, definitions, and standards for the data submitted, and require managed care and county-based purchasing plans to comply with these requirements.

(b) Requires each plan to annually provide to the commissioner: (1) administrative expenses by category and subcategory, by program; (2) revenues by program, including investment income; (3) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program; (4) data on the amount of reinsurance or transfer of risk by program; and (5) contribution to reserve, by program.

3 **Repealer.** Repeals § 256B.69, subd. 9b. (Requirement that managed care and county-based purchasing plans report data on provider payment rates to the commissioner).