MN HOUSE RESEARCH

Bill Summary

H.F. 3546

As amended by H3546DE1

Subject	Prepayment review requirements for Medical Assistance claims
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Overview

The DE1 amendment to H.F. 3546 directs the commissioner of human services to establish prepayment review of Medical Assistance (MA) fee-for-service claims when the commissioner or the Centers for Medicare and Medicaid Services (CMS) designate a provider type or a covered service as "high-risk." H3546DE1 sets out requirements for prepayment review, including prior notification to enrolled providers and the legislature and a report to the legislature when a prepayment review ends.

Summary

Section	Description
1	**Prepayment review.** Creates § 256B.044. **Subd. 1. Providers subject to prepayment review.** Directs the commissioner of human services to establish prepayment review of MA claims in specified circumstances, and allows the commissioner to establish review in additional circumstances if required by CMS. **Subd. 2. Review requirements.** Provides requirements for prepayment review, including when the review must be implemented and its maximum duration (24 months). Requires that the review comply with federal regulations with respect to timely processing of MA claims. Directs the commissioner to review 24 months of historical claims submitted by providers subject to the review prior to ending the review. **Subd. 3. Continued enrollment of new clients.** Provides that nothing in this section prohibits enrolled providers subject to prepayment review from enrolling new clients or beneficiaries during the period of review.

Section	Description

Subd. 4. Notice. Directs the commissioner to notify enrolled providers and the legislature at least ten days prior to implementing a prepayment review and specifies what must be included in the notice.

Subd. 5. Report to the legislature. Directs the commissioner to submit a report to the legislature within 60 days of ending a prepayment review. Requires that the report include: (1) a summary of sanctions imposed on any providers subject to the review; and (2) recommendations for modifying or terminating the provision of covered services deemed high-risk or delivered by provider types subject to the review. Provides that the reporting requirement does not expire.