Bill Summary Comparison of

Health and Human Services

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| Senate File: 3656-2 | House File 3138-3 |
| Article 22: Health Care  | Article 2: Health Care |

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| **Section 1 (3.3005, subdivision 8**) requires state agencies when making a request to the Legislative Advisory Commission, to spend federal funds to provide with the request a narrative description of the commitments required that includes whether continuation of any FTE positions will be a condition of receiving the federal funds. | Senate only section |  |
|  | House only section | Section 1. Classification. Amends § 13.69, subd. 1. Requires the Department of Public Safety to provide the last four digits of drivers’ Social Security numbers to DHS for purposes of recovery of Minnesota health care program benefits paid. Provides a July 1, 2018 effective date.  |
|  | See Senate article 24 comparison | Section 2. Mammograms. Amends § 62A.30, by adding subd. 4.  |
|  | See Senate article 24 comparison | Section 3. Short-term coverage. Amends § 62A.65, subd. 7.  |
| **Section 2 (62J.90)** establishes the Minnesota Health Policy Commission to make recommendations to the legislature on changes in health care policy and financing.  The commission is required to: (1) compare private market health care costs and public health care program spending to that of other states; (2) compare the private health care market care costs and public health care program spending in any given year to its costs and spending in previous years; (3) identify factors that influence and contribute to Minnesota’s ranking for private market health care costs and public health care program spending; (4) monitor efforts to reform the health care delivery and payment system to understand emerging trends in the health insurance market; (5) make recommendations for health care reform; and (6) conduct any additional reviews as required by the legislature. This commission expires June 15, 2024. | Senate only section |  |
|  | See Senate article 24 comparison | Section 4. Coverage restrictions or limitations. Amends § 62Q.55, subd. 5. |
| **Section 3 (256.01, subdivision 17a)** specifies that the Commissioner of Human Services may only transfer money from the general fund to another fund for routine administrative operations and may not transfer money from the general fund to any other fund for other purposes without the approval from the Commissioner of Management and Budget. | Technical differences only. Staff recommend Senate in paragraph (a) (placement of reference to authorization by law) and House in (b) (adds reference to “subsequently” withdrawing or changing recommendation). | **Article 11, Section 6.** **Transfers for routine administrative purposes.** Amends § 256.01, by adding subd. 17a. Allows the commissioner of human services to transfer money from the general fund to any other fund only for routine administrative operations, and prohibits a transfer from the general fund to any other fund without the approval of the commissioner of management and budget, unless authorized by law. Allows the commissioner of management and budget to approve a proposed transfer, if the commissioner determines it is necessary for routine administrative operations. If the commissioner of management and budget determines that a proposed transfer is not necessary for routine administrative operations, the commissioner may not approve the transfer unless the Legislative Advisory Commission, upon review, either makes a positive recommendation or no recommendation. |
|  | House only section | Section 5. Eligibility verification. Adds § 256.0113.  Subd. 1. Verification required; vendor contract. (a) Requires the commissioner to ensure that MA, MinnesotaCare, and Supplemental Nutrition Assistance Program (SNAP) eligibility determinations include the verification of income, residency, identity, and when applicable, assets and compliance with SNAP work requirements.(b) Requires the commissioner to contract with a vendor to verify the eligibility of MA, MinnesotaCare, and SNAP enrollees during a specified audit period. (c) Specifies the vendor to comply with data privacy requirements and to use encryption. Requires penalties for noncompliance.(d) Requires the contract to include a data sharing agreement, under which vendor compensation is limited to a portion of the savings.(e) Requires the commissioner to use existing resources to fund agency administrative and technology-related costs.(f) Requires state savings, after vendor payment, to be deposited into the health care access fund. Subd. 2. Verification process; vendor duties. (a) Specifies requirements for the verification process, which includes data matches against federal and state data sources.(b) Requires the vendor, upon preliminary determination that an enrollee is eligible or ineligible, to notify the commissioner. Requires the commissioner to accept or reject this determination within 20 days. States that the commissioner retains final authority over eligibility determinations. Requires the vendor to keep a record of all preliminary determinations.(c) Requires the vendor to recommend to the commissioner a process that allows ongoing verification of enrollee eligibility under MNsure and other agency eligibility determination systems.(d) Requires the commissioner and the vendor to jointly submit an eligibility verification audit report to legislative committees. Specifies requirements for the report.(e) Requires the vendor contract to be awarded for a one-year period, beginning January 1, 2019. Allows renewal for up to three years and additional verification audits, if the commissioner or legislative auditor determines that state eligibility determination systems cannot effectively verify MA, MinnesotaCare, and SNAP enrollee eligibility. |
|  | House only section | Section 6. State systems account created. Amends § 256.014, subd. 2. (a) Provides that any unexpended balance for information systems projects for MAXIS, PRISM, MMIS, ISDS, METS, or SSIS does not cancel and is available for ongoing development and operations, subject to review by the Legislative Advisory Commission (LAC) as provided in paragraphs (b) and (c).(b) Prohibits an unexpended balance under paragraph (a) from being expended by the commissioner of human services until the commissioner of management and budget has submitted the proposed expenditure to the LAC for review and recommendation. If the LAC makes a positive recommendation, no recommendation, or has not reviewed the request within 20 days of submittal, the commissioner of management and budget may approve the proposed expenditure. If the LAC recommends further review, the commissioner shall provide additional information to the LAC. If the LAC makes a negative recommendation within ten days, the commissioner shall not approve the expenditure. If the LAC makes a positive recommendation, or no recommendation within ten days, the commissioner may approve the expenditure.(c) Requires any LAC recommendation to be made at a meeting of the commission unless a written recommendation is signed by all members entitled to vote. States that a recommendation must be made by a majority of the commission.  |
| **Section 4 (256B.04, subdivision 14)** prohibits the commissioner from utilizing volume purchasing through competitive bidding for incontinence products and related supplies. | Senate only section |  |
| **Section 5 (256B.0625, subdivision 3b)** adds community paramedics to the health care providers who can receive medical assistance (MA) reimbursement for telemedicine services.  This section also creates an exception to the telemedicine visit limit if the telemedicine services are for the treatment and control of tuberculosis and are consistent with the best practices specified by the CDC. | Identical except:* House requires services to treat tuberculosis to be consistent with the recommendations and best practices of the CDC and the commissioner of health; Senate only refers to the CDC and not the commissioner of health.
* Technical differences in list of licensed providers (staff recommends Senate)
 | Section 7. Telemedicine services. Amends § 256B.0625, subd. 3b. Provides an exception to the MA limit on telemedicine services of three services per enrollee per calendar week, if the telemedicine services are: (1) provided by the licensed health care provider for the treatment and control of tuberculosis; and (2) provided in a manner consistent with the recommendations and best practices specified by the Centers for Disease Control and Prevention and the commissioner of health. Adds community paramedics to the list of licensed health care providers eligible to provide telemedicine services under MA. |
| **Section 6 (256B.0625, subdivision 17, paragraph (c))** requires drivers providing nonemergency medical transportation services (NEMT) who are employed by or subcontractors for seven-county metro-based nonemergency medical transportation providers or taxicabs to individually enroll with the commissioner by January 1, 2019. | Senate only section |  |
| **Section 7 (256B.0625. subdivision 17d)** requires DHS to perform ongoing program integrity audits of NEMT services to ensure that fee-for-service providers are complying with state and federal standards. | Identical | Section 8. Transportation services oversight. Amends § 256B.0625, by adding subd. 17d. Requires the commissioner to contract with a vendor or dedicate staff for the oversight of providers of nonemergency medical transportation services. |
| **Section 8 (256B.0625, subdivision 17e)** applies a five-year enrollment exclusion for terminated NEMT providers and requires a one-year probationary period upon reenrollment. | Identical, except Senate has 7/1/18 effective date and House section is effective the day following final enactment. | Section 9. Transportation provider termination. Amends § 256B.0625, by adding subd. 17e. (a) States that a terminated NEMT provider, including related individuals and affiliates, is not eligible to enroll as a NEMT provider for five years following termination.(b) Requires terminated providers who reenroll to be placed on a one-year probation period, during which the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements.Provides that the section is effective the day following final enactment. |
| **Section 9 (256B.0625, subdivision 17f)** requires the commissioner to provide documentation training for providers. | Senate only section |  |
|  | House only section | Section 10. Advisory committee members. Amends § 256B.0625, subd. 18d. Adds a taxicab owner or operator to the membership of the nonemergency medical transportation advisory committee. |

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|  | House only section | Section 11. Other clinic services. Amends § 256B.0625, subd. 30. Requires FQHCs and rural health clinics to submit claims for services provided on or after January 1, 2019, directly to the commissioner for payment. Requires the commissioner to provide claims information to managed care and county-based purchasing plans. (Under current law, DHS has the option to require FQHCs and rural health clinics to submit claims to the agency or to the managed care or county-based purchasing plan.) |
| **Section 10 (256B.0625, subdivision 58)** **Paragraph (b)** specifies that a provider is not required to provide as part of an EPSDT screening any of the recommendations added on or after January 1, 2017, to the child and teen checkup program schedule in order to receive the full payment reimbursement amount for a complete EPSDT screening.  This paragraph expires January 1, 2021.  **Paragraph (c)** requires the commissioner to inform the legislature of any new recommendations added to an EPSDT screening after January 1, 2018, that a provider is required to perform to receive full payment. | Senate only section |  |
|  | House only section | Section 12. Direct contracting pilot program. Adds § 256B.0759. Subd. 1. Establishment. Requires the commissioner of human services to establish a direct contracting pilot program, to test methods of care delivery through community-based collaborative care networks to MA and MinnesotaCare enrollees. Requires the program to be designed to coordinate care delivery to enrollees with a combination of risk factors. Requires the commissioner to issue an RFP to select care networks to deliver care for a three-year period, beginning January 1, 2020. Subd. 2. Eligible individuals. (a) Provides that the pilot program shall serve individuals who: (1) are eligible for MA or MinnesotaCare; (2) reside in the care network’s service area; (3) have multiple risk factors; (4) have elected to participate in the pilot program as an alternative to fee-for-service, managed care or county-based purchasing, or an integrated health partnership; and (5) agree to participate in risk mitigation strategies if determined to be at risk of opioid addiction or substance abuse.(b) Specifies methods the commissioner may use to identify eligible individuals. Requires the commissioner to coordinate pilot program enrollment with the enrollment and procurement process for managed care, county-based purchasing, and integrated health partnerships. Subd. 3. Selection of care networks. Limits participation to no more than six care networks and requires care networks to serve different geographic areas in the state. Specifies criteria to be used by the commissioner in selecting care networks. Subd. 4. Requirements for participating care networks. (a) Requires the care networks selected to: (1) accept the prepaid medical assistance program (PMAP) capitation rate; (2) comply with PMAP requirements related to performance targets, capitation rate withholds, and administrative expenses; (3) maintain adequate reserves and demonstrate the ability to bear risk, or demonstrate that this requirement has been met by contracting with a third-party; (4) assess all enrollees for risk factors related to opioid addiction and substance abuse, and based upon the professional judgment of the health care provider, require at-risk enrollees to enter into a patient provider agreement, submit to urine drug screening, or participate in other risk mitigation strategies; and (5) participate in quality of care and financial reporting initiatives.(b) Allows existing integrated health partnerships that meet program criteria to participate in the pilot program while continuing as an integrated health partnership. Subd. 5. Requirements for the commissioner. (a) Requires the commissioner to provide care networks with the enrollee utilization and cost information provided to integrated health partnerships.(b) Requires the commissioner, in consultation with the commissioner of health and care networks, to design and administer the pilot program to allow testing and evaluation of care models and quality of care measures, in order to compare the care delivered to that provided by managed care and county-based purchasing plans and integrated health partnerships.(c) Requires the commissioner, based on the analysis under paragraph (b), to evaluate the pilot program and present recommendations as to whether the program should be continued or expanded to the legislative committees with jurisdiction over health and human services policy and finance, by February 15, 2022. |
|  | House only section | Section 13. Managed care contracts. Amends § 256b.69, subd. 5a. A new paragraph (n) requires the commissioner, for services provided on or after January 1, 2019, through December 31, 2019, to withhold two percent of capitation payments provided to managed care and county-based purchasing plans 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, 2019. 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.A new paragraph (o) allows the commissioner to establish a single preferred drug list for MA and MinnesotaCare, only if the commissioner studies this change and then obtains legislative approval in the form of authorizing legislation. Requires the commissioner to consult with stakeholders in conducting the study, and to report to the legislative committees with jurisdiction over health and human services policy and finance on the anticipated impact of the change on: the state budget, access to services, quality of outcomes and enrollee experience, and administrative efficiency. Also requires the report to include an assessment of possible unintended consequences of the use of a single preferred drug list. |
| **Section 11 (256B.758)** increases the MA reimbursement rate for doula services to $47 per prenatal or postpartum visit up to a total of six visits; and $488 for attending and providing doula services at a birth, beginning July 1, 2018. | Senate only section |  |
| **Section 12** (**Laws 2017, First Special Session chapter 6, article 4, section 61)** modifies the capitation payment delay passed last session by exempting from the delay the capitation payment due in May 2021 to managed care organizations for adults without dependent children. | Senate only section |  |
| **Section 13 (Direction to the Commissioner)** requires the commissioner to submit a report to the legislature on the impact on NEMT program integrity of individual driver enrollment in the metro area. | Senate only section |  |
| **Section 14 (Minnesota Health Policy Commissioner; First Appointments; First Meeting)** specifies that the Legislative Coordinating Commission shall make the first appointments to the Minnesota Health Policy Commission by January 15, 2019. | Senate only section |  |
| **Section 15** **(Pain Management)** requires the Health Services Policy Committee, established by the Commissioner of Human Services, to evaluate the integration and make recommendations based on best practices for effective treatment for musculoskeletal pain provided by certain health practitioners and covered by medical assistance.  Requires the commissioner to consult with certain health practitioners and report to the legislature due August 1, 2019, on the commissioner's recommendations. The final report to the legislature must include a pilot program to assess integrated nonpharmacologic, multidisciplinary treatments for managing musculoskeletal pain. | Senate only section |  |
|  | House only section | Section 14. Encounter reporting of 340B eligible drugs. (a) Requires the commissioner of human services, in consultation with specified entities, to develop recommendations for 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, and to exclude these claims from the Medicaid drug rebate program and ensure that duplicate discounts do not occur. Requires the commissioner to assess the impact of allowing FQHCs to utilize 340B drug discounts if a FQHC utilizes a contract pharmacy for a patient enrolled in the prepaid medical assistance program.(b) Requires the commissioner, by March 1, 2019, to report recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over MA. |
|  | House only section | Section 15. Reconciliation of MinnesotaCare premiums.  Subd. 1. Reconciliation required. (a) Requires the commissioner of human services to reconcile all MinnesotaCare premiums paid or due for coverage for the period January 1, 2014 through December 31, 2017, by July 1, 2018. Requires the commissioner to notify each MinnesotaCare enrollee or former enrollee of any amount owed as premiums, refund any premium overpayments, and enter into payment arrangements as necessary.(b) Prohibits the commissioner from using agency staff or resources to plan, develop, or promote any proposal that would offer a health insurance product on the individual market with benefits and networks similar to MinnesotaCare, until the commissioner of management and budget has determined that the commissioner is in compliance with the requirements of this section. Subd. 2. Determination of compliance; contingent transfer. Requires the commissioner of management and budget to determine whether the commissioner of human services has complied with subdivision 1. Requires the commissioner of management and budget to transfer $10,000 from the central office operations account of DHS to the premium security plan account for each business day of noncompliance.Provides an immediate effective date. |
|  | House only section | Section 16. Contract to recover third-party liability. Requires the commissioner to contract with a vendor to implement a third-party liability recovery program for MA and MinnesotaCare. Provides that the vendor is to be reimbursed using a percentage of the money recovered. States that all money recovered, after reimbursement of the vendor, is for the operation of the MA and MinnesotaCare programs, and that the use of this money must be authorized in law by the legislature. Provides a July 1, 2018 effective date. |
|  | See Senate article 24 comparison | Section 17. Study and report on disparities between geographic rating areas in individual and small group health insurance rates. |
|  | See Senate article 24 comparison | Section 18. Testimony on use of digital breast tomosynthesis by members of state employee group insurance program. |
|  | See Senate article 24 comparison | Section 19. Mental health and substance use disorder parity work group. |
| **Section 16 (Repealer) Paragraph (a)** repeals section 256B.0625, subdivision 31c, (preferred incontinence product program passed last session). **Paragraph (b)** repeals the prohibition on the commissioner's use of a broker for the purposes related to NEMT services for ambulatory persons. | See Senate article 24 comparison | Section 20. Repealer.  |