Bill Summary Comparison of

Health and Human Services

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| House File 2414-2 | Senate File UEH2414-1 |
| Article 8: Health Care | Article 8: Department of Human Services; Health Care |

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| Section | Article 8: Health Care |  | Article 8: Department of Human Services; Health Care |
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|  | Classifications.Amends § 13.69, subd. 1. Requires the Department of Public Safety to provide the last four digits of the Social Security number to the Department of Human Services for recovery of Minnesota health care program benefits paid. Provides a July 1, 2019, effective date. | Identical | **Section 1 (13.69, subdivision 1)** requires the Department of Public Safety to provide to DHS the last four digits of a driver’s Social Security number for purposes of recovery of Minnesota health care program benefits paid. |
|  | Transfers.Amends § 16A.724, subd. 2. Makes a conforming change related to another section in the bill (adding § 256B.0625, subd. 67) which codifies a rider allowing a transfer from the health care access fund to the general fund. | House only |  |
|  | Licensed health care provider.Amends § 62A.671, subd. 6. Adds community health workers to the list of providers that can provide telemedicine services under private sector health plans and under MA. | House only |  |
|  | Definitions.Amends § 62Q.184, subd. 1.The amendment to paragraph (b) includes a preferred drug list developed by MA in the definition of “clinical practice guideline.”The amendment to paragraph (d) includes in the definition of health plan company managed care organizations, county-based purchasing plans, and integrated health partnerships participating in MA and Minnesota. These entities under current law are specifically excluded from the definition of health plan company (and therefore not required to comply with step therapy override requirements). | House only |  |
|  | Step therapy override process; transparency.Amends § 62Q.184, subd. 3.Allows enrollees or providers to appeal the denial of a step therapy override by a health plan company (including MA and MinnesotaCare) using the administrative review process established for human services programs. | House only |  |
|  | Protection from conversion therapy.Proposes coding for section 214.078. Subd. 1. Defines “conversion therapy.”Subd. 2. (a) Prohibits any mental health practitioner or mental health professional from engaging in conversion therapy with a client under age 18 or with a vulnerable adult, as defined in statute.(b) Specifies that engaging in conversion therapy with clients under 18 or with vulnerable adults may lead to disciplinary action taken by the provider’s relevant professional licensing board.Makes this section effective the day following final enactment. | House only |  |
|  | Controlling individual.Amends § 245A.02, subd. 5a. Updates a cross-reference. | House only |  |
|  | Program management and oversight.Amends § 245D.081, subd. 3. Updates a cross-reference and makes a technical edit. | House only |  |
|  | See House rider in Article 21, sec. 2, subd. 34, paragraph (b) | Similar language, except House specifies name of grantee; Senate refers to the grantee awarding “subgrants” and House refers to “grants” | **Section 2 (254A.21)** codifies, renames, and consolidates fetal alcohol spectrum disorders and prevention grants awarded by the commissioner of human services. |
|  | Incentive program.Amends § 256.962, subd. 5. Increases from $25 to $70 the application assistance bonus paid to navigators for enrolling individuals in MA. Provides a July 1, 2019, effective date. | House only |  |
|  | Hospital payment rates.Amends § 256.969, subd. 2b. Gives the commissioner ongoing authority to make additional payment adjustments to rebased hospital payment rates (under current law, this authority applies through the next two rebasing periods). | House only |  |
|  | Payments.Amends § 256.969, subd. 3a. Provides that payments for hospital discharges shall not exceed on a per claim, rather than aggregate as under current law, basis a hospital’s charges. | House only |  |
|  | Disproportionate numbers of low-income patients served.Amends § 256.969, subd. 9. The amendment to paragraph (d) modifies the DSH payment methodology. A new paragraph (f) requires the commissioner to establish an additional payment adjustment for hospitals that provide high levels of administering high-cost drugs to enrollees in fee-for-service MA. Requires the commissioner to consider fee-for-service MA utilization rates and payments for drugs purchased through the 340B program and administered to fee-for-service enrollees. If the adjustment exceeds a hospital’s specific disproportionate share hospital limit, requires the commissioner to make a payment to the hospital that equals the nonfederal share of the excess amount. Limits the total nonfederal share of adjustments to $1.5 million. States that the section is effective July 1, 2019, except paragraph (f) is effective for discharges on or after April 1, 2019. | House only |  |
|  | Out-of-state hospitals in local trade areas.Amends § 256.969, subd. 17. Modifies the admission threshold that governs when an out-of-state hospital has rates established using the procedures and methods that apply to Minnesota hospitals. | House only |  |
|  | Metabolic disorder testing of medical assistance recipients.Amends § 256.969, subd. 19. Provides that a payment increase related to the cost of metabolic disorder testing of newborns remains in effect until fully recognized in the base year cost. | House only |  |
|  |  | Senate only | ****Article 1, Section 22 (256B.02, subdivision 20)**** adds a definition of “income” in MA that includes deposits into accounts and funds in personal or business accounts that are used to pay personal expenses, and require documentation of the source for loans. |
|  | Competitive bidding.Amends § 256B.04, subd. 14. Allows the commissioner to volume purchase through competitive bidding and negotiation allergen-reducing products as described in section 256B.0625, subdivision 66, paragraph (c). | House allows volume purchase of allergen-reducing products.Senate prohibits the volume purchase of incontinence products and related supplies. | **Section 6 (256B.04, subdivision 14)** prohibits the commissioner from utilizing volume purchasing through competitive bidding for incontinence products and related supplies. This section is effective the day following final enactment. |
|  | Provider enrollment.Amends § 256B.04, subd. 21. (a) Requires the commissioner to enroll providers and conduct screening activities as required by federal regulations and specifies related requirements.(b) Requires the commissioner to revalidate each provider at least once every five years, and personal care assistance agencies once every three years.(c) Specifies criteria for conducting revalidations.(d) Allows the commissioner to suspend a provider’s ability to bill, if a provider fails to comply with any individual provider requirement or condition of participation. Provides that suspension is not subject to an administrative appeal.(e) Requires all correspondence and notifications to be delivered electronically, or by first-class mail if a provider does not have a MN-ITS account and mailbox. States that this does not apply to communications related to background studies.Provides a July 1, 2019, effective date. | Various differences:-- House requires background studies meeting specified criteria; Senate states that screening activities include database checks, site visits, fingerprinting, and criminal background studies; -- Senate requires individuals providing consumer directed community supports or supervising PCA services enroll as an individual provider-- Senate requires a surety bond to be in a form approved by the commissioner and renewed annually-- House provides that the requirement for electronic delivery does not apply to background studies-- Differences in phrasing throughout | **Article 1, Section 23 (256B.04, subdivision 21)** modifies requirements for provider enrollment in medical assistance; requires the commissioner to conduct provider screening activities consistent with federal law; requires the commissioner to revalidate enrollment of providers every five years and every three years for PCA providers; and requires individuals providing consumer-directed community supports or qualified professional services to enroll in medical assistance as individual providers; also modifies the surety bond requirements for durable medical equipment providers and suppliers. |
|  | Application fee.Amends § 256B.04, subd. 22. Strikes language that is reinstated in section 256B.04, subdivision 21. Provides a July 1, 2019, effective date. | House only |  |
|  | Subsidized foster children.Amends § 256B.055, subd. 2. Provides MA eligibility for children who are not eligible for Title IV-E assistance (federal payments for foster care) but are determined eligible for foster care or kinship assistance under chapter 256N. Provides a January 1, 2020, effective date. | House only |  |
|  |  | Senate only | **Section 7 (256B.056, subdivision 1)** requires the commissioner to identify individuals who are enrolled in medical assistance and are absent from the state for more than 30 consecutive days. If the individual is still deemed a resident of Minnesota and still eligible for medical assistance then any services provided to the individual must be paid through the fee for service system and not through managed care. |
|  |  | Senate only | **Article 1, Section 24 (256B.056, subdivisions 3)** amends the definition of “income” in MA, MFIP, housing assistance, GA, MSA, and MinnesotaCare to include deposits into accounts and funds in personal or business accounts that are used to pay personal expenses, and require documentation of the source for loans. |
|  | Asset limitations for certain individuals.Amends § 256B.056, subd. 3. Provides that MA will disregard a designated employment incentives asset account when determining MA eligibility for a person who is age 65 or older. Allows such an account to be designated only by a person enrolled in MA as an employed person with a disability (MA-EPD) for a 24-consecutive month period. Strikes existing language which allows a higher asset disregard ($20,000 for an individual after exclusions) for persons formerly eligible under MA-EPD who turn 65 and seek MA eligibility as a person who is elderly, blind, or has a disability (an asset limit of $3,000 for a household of one/$6,000 for a household of two normally applies to this group). Specifies criteria for a designated employment incentives asset account. Provides a July 1, 2019, effective date. | Identical language in paragraph (a). Paragraph (b) is Senate only. | **Section 8 (256B.056, subdivision 3) Paragraph (a)** provides a mechanism for people enrolled in medical assistance for employed persons with disabilities for 24 consecutive months without a lapse in medical assistance eligibility prior to turning 65 to protect many of their assets when they turn 65 by establishing a designated employment incentives asset account. **Paragraph (b)** states that upon renewal a single adult without children must not have more than $1,000,000 in assets to continue to be eligible for medical assistance. This paragraph is effective only upon federal approval. |
|  |  | Senate only | **Article 1, Section 25 (256B.056, subdivisions 4)** includes as assets deposits into accounts and funds in personal or business accounts that are used to pay personal expenses, and requires documentation of the source for loans. |
|  | Excess income standard.Amends § 256B.056, subd, 5c. Increases the MA spenddown standard for persons who have disabilities, are blind, or are age 65 or older to 83 percent of FPG, effective July 1, 2021. | House raises spenddown standard to 83% of FPG; Senate to 82% of FPG, effective January 1, 2020, and to 100% of FPG effective July 1, 2021. | **Section 9 (256B.056, subdivision 5c)** between January 1, 2020, and June 30, 2021, increases from 81 percent to 82 percent the medical spenddown requirement for persons whose medical assistance eligibility is based on blindness, disability or being 65 or older. Beginning July 1, 2021, the MA spenddown is eliminated. |
|  |  | Senate only | **Article 1, Section 26 (256B.056, subdivision 7a)** requires the commissioner of human services to annually reverify the eligibility of medical assistance participants, using a prepopulated renewal form that must be corrected and submitted by the participant. |
|  |  | Senate only | **Section 10 (256B.056, subdivision 7a)** authorizes a local agency to close an enrollee’s case file if the enrollee is terminated from medical assistance for failure to complete and return the required form and information within four months of termination. |
|  | Telemedicine services.Amends § 256B.0625, subd. 3b. Provides an exception from the limit on MA coverage of telemedicine (three services per enrollee per calendar week) if the:1. telemedicine services provided by the licensed health provider are for the treatment and control of tuberculosis; and
2. services are 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.
 | House only |  |
|  | Conversion therapy.Amends § 256B.0625 by adding subdivision 5m, specifying that conversion therapy is not covered by medical assistance. | House only |  |
|  | Dental services.Amends § 256B.0625, subd. 9.Expands MA coverage of dental services for nonpregnant adults, to include coverage of nonsurgical treatment for periodontal disease, including scaling and root planing once every two years for each quadrant, and routine periodontal maintenance procedures. | Different intent. House expands adult dental coverage to include treatment for periodontal disease; Senate limits adult dental coverage to only pregnant women and persons who are elderly, blind, or have disabilities. | **Section 11 (256B.0625, subdivision 9)** eliminates medical assistance coverage for dental services for nonpregnant adults who are not aged, blind, or disabled. |
|  |  | Senate only | **Section 12 (256B.0625, subdivision 12)** eliminates medical assistance coverage for vision services, eyeglasses, and dentures for nonpregnant adults who are not aged, blind, or disabled. |
|  | Drugs.Amends § 256B.0625, subd. 13. Strikes language relating to the quantity of over-the-counter medications that may be dispensed. States that the section is effective April 1, 2019, or upon federal approval, whichever is later. | Identical | **Section 13 (256B.0625, subdivision 13)** strikes language specifying the quantity of over-the-counter medications to be dispensed. |
|  | Drug formulary.Amends § 256B.0625, subd. 13d.Allows MA to cover drugs or active pharmaceutical ingredients used for weight loss. Under current law, the MA formulary only covers drugs for weight loss if they are medically necessary lipase inhibitors used by recipients with Type II diabetes. | House only |  |
|  | Payment rates.Amends § 256B.0625, subd. 13e. Amends § 256B.0625, subd. 13e. Makes a variety of changes to MA payment methods for outpatient prescription drugs. The changes made in paragraph (a) include:* setting payment based on the ingredient cost of the drugs plus a professional dispensing fee
* defining usual and customary price
* setting the dispensing fee for drugs meeting the federal definition of “covered outpatient drugs” at $10.48 and specifying dispensing fees for other types of drugs
* requiring dispensing fees to be pro-rated based upon the quantity of a drug dispensed
* setting the ingredient cost for providers participating in the federal 340B program at the 340B ceiling price or the National Average Drug Acquisition Cost (NADAC), whichever is lower

requiring 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 (current law sets the maximum amount as that paid by third party payors with maximum allowable cost programs)The amendment to paragraph (c) eliminates add-ons to the dispensing fee for certain drugs dispensed to long-term care facility residents using a unit dose blister card system.The amendment to paragraph (d) sets the ingredient cost of a multisource drug at the NADAC of the generic product, or the maximum allowable cost established by the commissioner.The amendment to paragraph (e) increases, from 20 to 28.6 percent, the discount from the payment rate for drugs obtained through the 340B program.The amendment to paragraph (f) adds references to the maximum allowable cost and makes changes in terminology, in a provision of law dealing with specialty pharmacy products.A new paragraph (h) requires the commissioner to contract with a vendor to conduct cost of dispensing surveys for Minnesota pharmacies. Specifies criteria for the survey. Requires the initial survey to be completed by January 1, 2021, and repeated every three years.A new paragraph (i) requires the commissioner to increase the ingredient cost by two percent for prescription and nonprescription drugs subject to the MinnesotaCare wholesale distributor tax.States that the section is effective April 1, 2019, or upon federal approval, whichever is later. States that paragraph (i) expires if federal approval is denied. | Identical, except House adds (i), which provides a 2% rate increase to reflect the wholesale distributor tax, and also provides that (i) expires if federal approval is denied. | **Section 14 (256B.0625, subdivision 13e)** specifies that the usual and costmary price means the lowest price charged by the provider to a patient who pays for the drug and includes prices charged to a patient enrolled in a prescription savings club or discount club administered by the pharmacy or pharmacy chain. This section also requires that prescription drugs be reimbursed on the actual acquisition cost according to nationally recognized benchmarks. It also increases the dispensing fee for pharmacy providers from $3.85 to $10.48 and establishes ongoing cost dispensing surveys to be conducted every three years. It also aligns reimbursement for drugs purchased through the federal 340B program requiring that reimbursement for these drugs be at the provider’s cost. |
|  | Prior authorization.Amends § 256B.0625, subd. 13f. Eliminates the prohibition on use of prior authorization for certain antihemophilic factor drugs. Provides an immediate effective date.Paragraph (f) requires MA prior authorization procedures to comply with step therapy override requirements under section 62Q.184.Provides an immediate effective date, except that paragraph (f) is effective July 1, 2019. | Identical on eliminating the prohibition on prior authorization for antihemophilic drugs.House in paragraph (f) requires DHS to comply with step therapy override requirements; Senate does not include this provision. | **Section 15 (256B.0625, subdivision 13f)** strikes language that prohibits the commissioner from requiring prior authorization from being used for antihemophilic factor drug where there is no generically equivalent drug in conjunction with a supplemental drug rebate program or multistate preferred drug program. |
|  | Transportation costs.Amends § 256B.0625, subd. 17. Requires all nonemergency medical transportation drivers to be individually enrolled with the commissioner and reported on the claim as the individual providing the service. Removes language requiring consultation with the Minnesota Department of Transportation. Provides a July 1, 2019, effective date. | House requires all drivers to be individually enrolled and listed on the claim; Senate requires individual enrollment if the driver is a subcontractor for or employed by a provider that has a base of operation within a metro county, and is a NEMT provider or provides taxicab services.Different effective dates: House 7-1-19 and Senate 7-1-20. | ****Article 1, Section 27 (256B.0625, subdivision 17)**** requires individual drivers providing nonemergency medical transportation NEMT services to enroll as individuals if the NEMT provider by whom they are employed is based in the Twin Cities metropolitan area. |
|  | Transportation services oversight.Amends § 256B.0625, by adding subd. 17d. Requires the commissioner to contract with a vendor or dedicate staff to oversee providers of nonemergency medical transportation (NEMT) services. Provides a July 1, 2019, effective date. | Technical differences.Different effective dates: House, July 1, 2019; Senate, July 1, 2020. | ****Article 1, Section 28 (256B.0625, subdivision 17d)**** requires the commissioner to apply the commissioner’s existing oversight authority to NEMT providers, and permits the commissioner to do so through a contract with a vendor. |
|  | Transportation provider termination.Amends § 256B.0625, by adding subd. 17e. Prohibits a terminated NEMT provider from enrolling as a NEMT provider for five years following termination. If the provider seeks reenrollment after the five-year period, requires the provider to be placed on a one-year probation, during which the commissioner shall complete unannounced site visits and request documentation to review compliance with program requirements. Provides an immediate effective date. | Technical differences.Different effective dates: House the day following final enactment; Senate July 1, 2019. | ****Article 1, Section 29 (256B.0625, subdivision 17e)**** excludes for five years from the NEMT program a terminated NEMT provider and specifies the circumstances under which a previously excluded NEMT provider may enroll as an NEMT provider. |
|  |  | Senate only | ****Article 1, Section 30 (256B.0625, subdivision 17f)**** requires the commissioner to provide documentation requirements training to NEMT providers and drivers. |
|  |  | Senate only | **Section 16 (256B.0625, subdivision 18d)** adds a taxicab owner to the nonemergency medical transportation advisory committee. |
|  |  | Senate only | **Article 1, Section 31 (256B.0625, subdivision 18h)**requires all NEMT providers under managed care to enroll with the Department of Human Services as an NEMT provider. |
|  | Other clinic services.Amends § 256B.0625, subd. 30. A new paragraph (g) provides that for services provided on or after January 1, 2021, claims for clinic services provided by federally qualified health centers (FQHCs) and rural health clinics shall be paid by the commissioner, according to an annual election by the center or clinic, under the current prospective payment system in paragraph (f) or the alternative payment methodology in paragraph (l).A new paragraph (l) establishes the alternative payment methodology. Provides that all claims for payment of clinic services provided by FQHCs and rural health clinics shall be paid according to specified requirements.This section also replaces references to federally qualified health centers with “FQHC” throughout. | House only |  |
|  | Medical supplies and equipment.Amends § 256B.0625, subd. 31. States that allergen-reducing products provided according to subdivision 66, paragraph (c), shall be considered durable medical equipment. States that the section is effective January 1, 2020, or upon federal approval, whichever is later. | House only |  |
|  | Payment for Part B Medicare crossover claims.Amends § 256B.0625, subd. 57. Exempts Indian Health Services from a provision that limits MA payment of an enrollee’s Medicare Part B cost-sharing to the MA allowed amount, when the MA rate exceeds the amount paid by Medicare. Provides an immediate effective date. | House only |  |
|  | Enhanced asthma care services.Amends § 256B.0625, by adding subd. 66. (a) States that MA covers enhanced asthma care services and related products provided in children’s homes for children with poorly controlled asthma. To be eligible, requires a child:(1) to be under age 21;(2) to have poorly controlled asthma, defined as having received asthma care from a hospital emergency department at least once in the past year or having been hospitalized for the treatment of asthma at least one in the past year; and(3) to have received a referral for services and products under this subdivision from a treating health care provider.(b) States that covered services include home visits provided by a registered environmental health specialist or lead risk assessor credentialed by the Department of Health or a healthy homes specialist credentialed by the Building Performance Institute.(c) Requires covered products to be identified and recommended for the child by a registered environmental health specialist, healthy homes specialist, lead risk assessor, certified asthma educator, public health nurse, or other health professional providing asthma care, and proven to reduce asthma triggers. Lists specific products covered. Allows the commissioner to determine other products that may be covered, as new best practices for asthma are identified.(d) Defines a home assessment as a home visit to identify asthma triggers and to provide education on trigger-reducing products. Limits a child to two home assessments, except that an additional home assessment may be provided if the child moves to a new home, a new asthma trigger enters the home, or if the child’s health care provider identifies a new allergy for the child. Requires the commissioner to determine the frequency with which a child may receive a product listed in paragraph (c), based on the reasonable expected lifetime of the product.States that the section is effective January 1, 2020, or upon federal approval, whichever is later. | House only |  |
|  |  | Senate only | **Section 17 (256B.0625, subdivision 66)** requires medical assistance to cover PPEC center basic services. |
|  | Provider tax rate increase.Amends § 256B.0625, by adding subd. 67. Moves from rider into statute a provision that increases MA and MinnesotaCare payments to managed care plans and MA and MinnesotaCare fee-for-service payments, to reflect MA and MinnesotaCare being subject to the MinnesotaCare provider taxes and the HMO premium tax. | House only |  |
|  | Grounds for sanctions against vendors.Amends § 256B.064, subd. 1a. Allows the commissioner to impose sanctions against a pharmacy for failure to respond to a cost of dispensing survey. Provides an effective date of April 1, 2019. | Identical | **Section 18 (256B.064, subdivision 1a)** authorizes the commissioner to impose sanctions against a pharmacy provider for failure to respond to a cost of dispensing survey required under section 256B.0625, subdivisions 13e, paragraph (h). |
|  | Requirements for provider enrollment of personal care assistance provider agencies.Amends § 256B.0659, subd. 21. The amendment to paragraph (a) clarifies that personal care provider agencies must provide to the commissioner at the time of enrollment, reenrollment, and revalidation, bond coverage and other information for each business location. Also makes related changes. The amendment to paragraph (c) requires specified employees of personal care provider agencies to complete required training before submitting an application for agency enrollment.A new paragraph (d) requires all surety bonds, fidelity bonds, workers compensation insurance, and liability insurance to be maintained continuously, and specifies related requirements.Provides an immediate effective date. | No overlap in language – differences are as described in House and Senate summaries. | ****Article 1, Section 43 (256B.0659, subdivision 21)****modifiesprovider agency enrollment requirements to include submitting copies of policies related to fraud prevention and preventing inadequate documentation; self-auditing policies; program integrity policies; and, for first-time enrollees, proof of adequate operating capital. Also included is a requirement that PCA agencies provide DHS with payroll documentation and demonstrate that the agency is complying with the existing requirement that 72.5 percent of the provider's revenue from MA for PCA services is passed through to PCAs in the form of wages and benefits. |
|  |  | Senate only | **Section 19 (256B.69, subdivision 4)** specifies that an individual who is absent from the state for more than 30 consecutive days but still eligible for medical assistance is not required to be enrolled in managed care.  |
|  |  | Senate only | **Section 20 (256B.69, subdivision 31)** reduces the maximum trend increases to the rates paid to managed care plans and county based purchasing plans by 1.6% for calendar years 2020, 2021, 2023, and 2024. |
|  | Payment rate transparency.Amends § 256B.69, by adding subd. 38. Requires the commissioner to compare fee-for-service MA, Medicare, and MA managed care and county-based purchasing plan aggregate payment rates for the most frequently used services, and publish and update this information on the DHS website. Provides an October 1, 2020, effective date. | House only |  |
|  | Reimbursement for doula services. Adds § 256B.758. For services provided on or after July 1, 2019, sets MA payment rates for doula services provided by a certified doula at $47 per prenatal or postpartum visit and $488 for attending and providing doula services at birth. | House only |  |
|  | Reimbursement for basic care services.Amends § 256B.766. Requires payment rates for durable medical equipment, prosthetics, orthotics, or supplies subject to the Medicare limit to be paid at the Medicare rate. States that the section is effective July 1, 2019, subject to federal approval. | House only |  |
|  | Grant program established.Amends § 256B.79, subd. 2. Modifies the integrated care for high-risk pregnant women pilot program to be continuing grant program. | House only |  |
|  | Grant awards.Amends § 256B.79, subd. 3. Removes obsolete date. Specifies that priority in awarding grants must be given to qualified integrated perinatal care collaboratives that have received grants under the pilot program before January 2019. | House only |  |
|  | Eligibility for grants.Amends § 256B.79, subd. 4. Updates language to reflect change to continuing grant program. | House only |  |
|  | Gaps in communication, support, and care.Amends § 256B.79, subd. 5. Updates language to reflect change to continuing grant program. | House only |  |
|  | Report.Amends § 256B.79, subd. 6. Requires the commissioner to report to the legislature by January 31, 2021, and every two years thereafter, about the outcomes of the grant program. Updates language to reflect change to continuing grant program. | House only |  |
|  |  | Senate only | **Section 21 (256B.86)** establishes reimbursement rates for PPEC basic services covered by medical assistance and provided in licensed PPEC centers. |
|  |  | Senate only | Article 1 (256L.01, subdivision 5) modifies the definition of income for MinnesotaCare to include amounts deposited into checking and savings accounts for personal expenses. |
|  |  | Senate only | **Section 22 (256L.03, subdivision 5)** reduces the actuarial value for MinnesotaCare to 87 percent for families or individuals with incomes above 150% of the federal poverty guidelines and equal to or less than 200% of the federal poverty guidelines. |
|  |  | Senate only | **Section 23 (256L.03, subdivision 7)** modifies the services covered under MinnesotaCare to the services covered under medical assistance under the Minnesota EHB Benchmark Plan or the actuarial equivalent. |
|  | Payment of certain providers.Amends § 256L.11, subd. 2. Provides that alternative payment methodologies shall not apply to MinnesotaCare services provided by FQHCs, rural health clinics, Indian Health Service facilities, and certified behavioral health clinics. | House only |  |
|  | Contingent reduction in tax.Amends § 295.52, subd. 8. Makes a conforming change related to the continuation of the MinnesotaCare provider tax. Provides an effective date of the day following final enactment. | House only |  |
|  | Advertisement and sales; misrepresentation of conversion therapy.Amends § 325F.69 by adding a subdivision. Prohibits any person or entity from using any fraudulent or deceptive practices when advertising for or offering conversion therapy. Defines “conversion therapy.” | House only |  |
|  | Basic health care grants.Amends Laws 2003, 1st Spec. Sess. ch. 14, art. 13C, § 2, subd. 6, as further amended. Strikes rider language that increased MA and MinnesotaCare managed care payment rates for costs related to elimination of the exemption from the insurance premium and MinnesotaCare provider taxes, and increased fee-for-service rates for payments related to the MinnesotaCare provider tax. (These provisions are reinstated in this bill as codified language.) | House only |  |
|  | Study of clinic costs.Requires the Commissioner of Human Services to conduct a five-year comparative analysis of the actual change in FQHC and rural health clinic costs versus the CMS FQHC Market Basket inflator, and report findings to the legislature by July 1, 2025. | House only |  |
|  |  | Senate only | **Section 24** **[Corrective Plan to Eliminate Duplicate Personal Identification Numbers]** requires the commissioner of human services to design and implement a corrective plan to address the issue of MA enrollees being assigned more than one personal identification number.  Requires any fixes or corrections to be made by June 30, 2021. This section also requires the commissioner to submit to the legislature a report on the progress of the corrective plan by February 15, 2020, and information on the number of enrollees that have been assigned two or more personal identification numbers; any possible financial effect of enrollees having supplicate numbers; and any effect on federal payments received by the state. |
|  |  | Senate only | **Section 25 [Direction to the Commissioner of Human Services; Quality Measures For PPEC centers]** requires the commissioner of human services to develop quality measures for PPEC centers, procedures for reporting quality measures and methods for the commissioner to make the results of the quality measures available to the public.  |
|  |  | Senate only | **Section 26 (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 by August 1, 2020, 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 | **Article 1, Section 66 (Direction to the Commissioner; NEMT driver enrollment impact)** requires the commissioner to study the impact of individual driver enrollment on the integrity of the NEMT program and to report the study’s findings to the legislature. |
|  |  | Senate only | **Article 1, Section 68 (Direction to the Commissioner; federal waivers)** directs the commissioner of human services to seek any necessary federal waivers for the removal of self-attestation when establishing eligibility for medical assistance. |
|  | Repealer.(a) Repeals sections 256B.0625, subdivision 63 (payment to clinics for mental health or dental services provided on the same day; this concept is included in the alternative payment methodology described in section 256B.0625, subdivision 30, paragraph (l)); 256B.0659, subdivision 22 (annual review of PCA provisions); and 256L.11, subdivision 2a (provision allowing higher payment rates for FQHC services provided to MinnesotaCare families and children).(b) Repeals section 256B.79, subdivision 7 (specifies a June 30, 2019, expiration date for section 256B.79), effective the day following final enactment.(c) Repeals Laws 2011, First Special Session chapter 9, article 6, section 97, subdivision 6, effective the day following final enactment. This provision repeals the MinnesotaCare provider tax, effective for gross revenues received after December 31, 2019. | House only |  |
|  |  | Senate only | **Section 27 [Repealer]** repeals section 16A.724, subdivision 2 (transfers from the health care access fund to the general fund) and section 256B.0625, subdivision 31c (preferred incontinence product program). Both repeals are effective the day following final enactment. |