State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 601

01/30/2017 Authored by Lohmer, Theis, Green, Newberger, Bahr, C., and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
05/21/2017 Returned to Author

A bill for an act

relating to human services; providing commissioner of human services with additional authority to sanction and terminate state health care program providers; establishing financial reporting requirements for abortion services; modifying payment procedures for abortion services; amending Minnesota Statutes 2016, sections 256B.04, subdivision 21, by adding a subdivision; 256B.0625, by adding a subdivision; 256B.064, subdivision 1a.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2016, section 256B.04, subdivision 21, is amended to read:

Subd. 21. **Provider enrollment.** (a) If the commissioner or the Centers for Medicare and Medicaid Services determines that a provider is designated "high-risk," the commissioner may withhold payment from providers within that category upon initial enrollment for a 90-day period. The withholding for each provider must begin on the date of the first submission of a claim.

(b) An enrolled provider that is also licensed by the commissioner under chapter 245A, or is licensed as a home care provider by the Department of Health under chapter 144A and has a home and community-based services designation on the home care license under section 144A.484, must designate an individual as the entity's compliance officer. The compliance officer must:

(1) develop policies and procedures to assure adherence to medical assistance laws and regulations and to prevent inappropriate claims submissions;

(2) train the employees of the provider entity, and any agents or subcontractors of the provider entity including billers, on the policies and procedures under clause (1);

(3) respond to allegations of improper conduct related to the provision or billing of medical assistance services, and implement action to remediate any resulting problems;

(4) use evaluation techniques to monitor compliance with medical assistance laws and regulations;

(5) promptly report to the commissioner any identified violations of medical assistance laws or regulations; and

(6) within 60 days of discovery by the provider of a medical assistance reimbursement overpayment, report the overpayment to the commissioner and make arrangements with the commissioner for the commissioner's recovery of the overpayment.

The commissioner may require, as a condition of enrollment in medical assistance, that a provider within a particular industry sector or category establish a compliance program that contains the core elements established by the Centers for Medicare and Medicaid Services.

(c) The commissioner may revoke the enrollment of an ordering or rendering provider for a period of not more than one year, if the provider fails to maintain and, upon request from the commissioner, provide access to documentation relating to written orders or requests for payment for durable medical equipment, certifications for home health services, or referrals for other items or services written or ordered by such provider, when the commissioner has identified a pattern of a lack of documentation. A pattern means a failure to maintain documentation or provide access to documentation on more than one occasion. Nothing in this paragraph limits the authority of the commissioner to sanction a provider under the provisions of section 256B.064.

(d) The commissioner shall terminate or deny the enrollment of any individual or entity if the individual or entity has been terminated from participation in Medicare or under the Medicaid program or Children's Health Insurance Program of any other state.

(e) According to federal law, the commissioner shall revoke or deny enrollment of a provider that has a:

(1) criminal conviction related to:

(i) patient abuse or neglect;

(ii) health care fraud; or

(iii) controlled substances; or

(2) termination for cause under the State Children's Health Insurance Program under title XXI of the Social Security Act, title 42, sections 1397aa et seq., or under Health

Insurance for Aged and Disabled under title XVIII of the Social Security Act, title 42, sections 1395 et seq.

~~(e)~~ (f) As a condition of enrollment in medical assistance, the commissioner shall require that a provider designated "moderate" or "high-risk" by the Centers for Medicare and Medicaid Services or the commissioner permit the Centers for Medicare and Medicaid Services, its agents, or its designated contractors and the state agency, its agents, or its designated contractors to conduct unannounced on-site inspections of any provider location. The commissioner shall publish in the Minnesota Health Care Program Provider Manual a list of provider types designated "limited," "moderate," or "high-risk," based on the criteria and standards used to designate Medicare providers in Code of Federal Regulations, title 42, section 424.518. The list and criteria are not subject to the requirements of chapter 14. The commissioner's designations are not subject to administrative appeal.

~~(f)~~ (g) As a condition of enrollment in medical assistance, the commissioner shall require that a high-risk provider, or a person with a direct or indirect ownership interest in the provider of five percent or higher, consent to criminal background checks, including fingerprinting, when required to do so under state law or by a determination by the commissioner or the Centers for Medicare and Medicaid Services that a provider is designated high-risk for fraud, waste, or abuse.

~~(g)~~ (h)(1) Upon initial enrollment, reenrollment, and notification of revalidation, all durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) medical suppliers meeting the durable medical equipment provider and supplier definition in clause (3), operating in Minnesota and receiving Medicaid funds must purchase a surety bond that is annually renewed and designates the Minnesota Department of Human Services as the obligee, and must be submitted in a form approved by the commissioner. For purposes of this clause, the following medical suppliers are not required to obtain a surety bond: a federally qualified health center, a home health agency, the Indian Health Service, a pharmacy, and a rural health clinic.

(2) At the time of initial enrollment or reenrollment, durable medical equipment providers and suppliers defined in clause (3) must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is up to and including $300,000, the provider agency must purchase a surety bond of $50,000. If a revalidating provider's Medicaid revenue in the previous calendar year is over $300,000, the provider agency must purchase a surety bond of $100,000. The surety bond must allow for recovery of costs and fees in pursuing a claim on the bond.

(3) "Durable medical equipment provider or supplier" means a medical supplier that can purchase medical equipment or supplies for sale or rental to the general public and is able to perform or arrange for necessary repairs to and maintenance of equipment offered for sale or rental.

~~(h)~~ (i) The Department of Human Services may require a provider to purchase a surety bond as a condition of initial enrollment, reenrollment, reinstatement, or continued enrollment if: (1) the provider fails to demonstrate financial viability, (2) the department determines there is significant evidence of or potential for fraud and abuse by the provider, or (3) the provider or category of providers is designated high-risk pursuant to paragraph (a) and as per Code of Federal Regulations, title 42, section 455.450. The surety bond must be in an amount of $100,000 or ten percent of the provider's payments from Medicaid during the immediately preceding 12 months, whichever is greater. The surety bond must name the Department of Human Services as an obligee and must allow for recovery of costs and fees in pursuing a claim on the bond. This paragraph does not apply if the provider currently maintains a surety bond under the requirements in section 256B.0659 or 256B.85.

Sec. 2. Minnesota Statutes 2016, section 256B.04, is amended by adding a subdivision to read:

Subd. 25. **Provider reporting requirement.** (a) The commissioner shall require vendors of medical care to document, for each abortion service provided to each patient, the portion of the total vendor cost related to:

(1) professional services related to performance of the abortion;

(2) professional services for preprocedure and postprocedure visits related to the performance of the abortion; and

(3) facility, administrative, and overhead costs related to performance of the abortion, reported separately for the services described in clauses (1) and (2).

(b) Vendors shall submit the documentation identified in paragraph (a) to the commissioner, for each abortion service provided to each patient, in the manner specified by the commissioner.

Sec. 3. Minnesota Statutes 2016, section 256B.0625, is amended by adding a subdivision to read:

Subd. 16a. **Payment for abortion services.** (a) Medical assistance payment for abortion services is limited to payment for:

(1) professional services related to performance of the abortion; and

(2) professional services for preprocedure and postprocedure visits related to the performance of the abortion.

(b) Medical assistance payment shall not be provided for facility, administrative, and overhead costs related to performance of the abortion.

Sec. 4. Minnesota Statutes 2016, section 256B.064, subdivision 1a, is amended to read:

Subd. 1a. **Grounds for sanctions against vendors.** The commissioner may impose sanctions against a vendor of medical care for any of the following:

(1) fraud, theft, or abuse in connection with the provision of medical care to recipients of public assistance;

(2) a pattern of presentment of false or duplicate claims or claims for services not medically necessary or that fail to meet professionally recognized standards of care;

(3) a pattern of making false statements of material facts for the purpose of obtaining greater compensation than that to which the vendor is legally entitled;

(4) suspension or termination as a Medicare vendor;

(5) refusal to grant the state agency access during regular business hours to examine all records necessary to disclose the extent of services provided to program recipients and appropriateness of claims for payment;

(6) failure to repay an overpayment or a fine finally established under this section;

(7) failure to correct errors in the maintenance of health service or financial records for which a fine was imposed or after issuance of a warning by the commissioner; ~~and~~

(8) any reason for which a vendor could be excluded from participation in the Medicare program under section 1128, 1128A, or 1866(b)(2) of the Social Security Act;

(9) accepting a payment kickback or engaging in another activity prohibited under federal law;

(10) submitting a claim for services furnished by a provider under sanction by federal or state government;

(11) failure to supply payment and other information required or requested by the commissioner;

(12) making a false statement or misrepresenting a material fact relating to the provision of services and billing for those services;

(13) failure to ensure that services or items are provided economically and only when, and to the extent, medically necessary;

(14) failure to ensure that a service or item is of a quality that meets professionally recognized standards of health care that are supported by evidence of necessity and quality;

(15) being found liable for patient neglect that results in the death of, or injury to, the patient;

(16) submittal of a claim for an abortion or related services when claim submittal would violate federal or state law;

(17) failure to comply with the provider reporting requirements specified in section 256B.04, subdivision 25; and

(18) failure to comply with a federal or state law requiring mandatory reporting of child sexual abuse, child sexual assault, child sex trafficking, or statutory rape.

Sec. 5. **SEVERABILITY.**

The provisions of this act are severable. If a provision of this act, or its application to any person, entity, or circumstance, is held to be invalid, this invalidity shall not affect those provisions or applications of this act that can be given effect without the invalid provision or application.