SENATE
STATE OF MINNESOTA
NINETY-FIRST SESSION

S.F. No. 3943

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DATE	D-PG	OFFICIAL STATUS
03/04/2020	5230	Introduction and first reading Referred to Commerce and Consumer Protection Finance and Policy

A bill for an act

relating to health care; modifying prompt payment requirements to health care providers; prohibiting discrimination against providers based on geographic location; modifying managed care organization's claims and payments to health care providers; amending Minnesota Statutes 2018, sections 62Q.735, subdivision 2; 62Q.736; 62Q.75, subdivisions 2, 3, 4; 256B.0625, subdivision 31; 256B.69, by adding a subdivision; proposing coding for new law in Minnesota Statutes, chapter 62K.

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

Section 1. **[62K.106] NONDISCRIMINATION AGAINST PROVIDERS WITHIN A GEOGRAPHIC AREA.**

(a) Notwithstanding any law to the contrary, no health carrier shall deny a health care provider the right to contract with the health carrier as an in-network provider in any health plan offered and actively marketed by the health carrier within the same geographic area in which the provider's primary practice is located. For purposes of this section, "geographic area" means the Minnesota specific geographic rating areas established for purposes of insurance rate pricing within the state.

(b) The health carrier may require the provider to meet reasonable referral, utilization review, and quality assurance requirements on the same basis as other in-network providers.

(c) This section applies to health plans offered by managed care organizations and county-based purchasing plans under a public health care program under chapter 256B or 256L.

(d) Nothing in this section shall be construed to waive any exclusions of coverage under the terms and conditions of an enrollee's health plan or require a health carrier to provide coverage for a health care service that is not covered under an enrollee's health plan.

Sec. 2. Minnesota Statutes 2018, section 62Q.735, subdivision 2, is amended to read:

Subd. 2. **Proposed amendments.** (a) Any amendment or change in the terms of an existing contract between a health plan company and a provider must be disclosed to the provider at least 45 days prior to the effective date of the proposed change, with the exception of amendments required of the health plan company by law or governmental regulatory authority, when notice shall be given to the provider when the requirement is made known to the health plan company.

(b) Any amendment or change in the contract that alters the fee schedule or materially alters the written contractual policies and procedures governing the relationship between the provider and the health plan company must be disclosed to the provider not less than ~~45~~ 90 days before the effective date of the proposed change and the provider must have the opportunity to terminate the contract before the amendment or change is deemed to be in effect.

(c) By mutual consent, evidenced in writing in amendments separate from the base contract and not contingent on participation, the parties may waive the disclosure requirements under paragraphs (a) and (b).

(d) Notwithstanding paragraphs (a) and (b), the effective date of contract termination shall comply with the terms of the contract when a provider terminates a contract.

Sec. 3. Minnesota Statutes 2018, section 62Q.736, is amended to read:

62Q.736 PAYMENT RATES.

(a) A contract between a health plan company and a provider shall comply with section 62A.64.

(b) No health plan company or third-party administrator shall refuse to negotiate with a provider because the provider has a designated contract negotiator or refuse to negotiate with a provider's designated contract negotiator. No health plan company or third-party administrator shall refuse to negotiate with a provider because the provider's designated contract negotiator is working for or on behalf of one or more providers.

Sec. 4. Minnesota Statutes 2018, section 62Q.75, subdivision 2, is amended to read:

Subd. 2. **Claims payments.** (a) This section applies to clean claims submitted to a health plan company or third-party administrator for services provided by any:

(1) health care provider, as defined in section 62Q.74, but does not include a provider licensed under chapter 151;

(2) home health care provider, as defined in section 144A.43, subdivision 4; or

(3) health care facility.

All health plan companies and third-party administrators must pay or deny claims that are clean claims within 30 calendar days after the date upon which the health plan company or third-party administrator received the claim.

(b) The health plan company or third-party administrator shall, upon request, make available to the provider information about the status of a claim submitted by the provider consistent with section 62J.581.

(c) If a health plan company or third-party administrator does not pay or deny a clean claim within the period provided in paragraph (a), the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date on which the health plan company or third-party administrator makes the payment or denies the claim. In any payment, the health plan company or third-party administrator must itemize any interest payment being made separately from other payments being made for services provided. The health plan company or third-party administrator shall not require the health care provider to bill the health plan company or third-party administrator for the interest required under this section before any interest payment is made. Interest payments must be made to the health care provider no less frequently than quarterly.

(d) If a health plan company or third-party administrator makes a partial payment on a clean claim, the health plan company or third-party administrator must pay interest on the claim for the period beginning on the day after the required payment date specified in paragraph (a) and ending on the date the health plan company or third-party administrator makes full payment on the claim.

~~(d)~~ (e) The rate of interest paid by a health plan company or third-party administrator under this subdivision shall be 1.5 percent per month or any part of a month. If a health plan company or third-party administrator fails to pay interest to a provider as required under

this subdivision, the health plan company or third-party administrator shall be liable for all costs, including legal fees, incurred by the provider to collect the unpaid interest.

~~(e)~~ (f) A health plan company or third-party administrator is not required to make an interest payment on a claim for which payment has been delayed for purposes of reviewing potentially fraudulent or abusive billing practices, if the review is based on a reasonable, good faith basis that the provider has engaged in fraudulent or abusive billing practices.

~~(f)~~ (g) The commissioner may assess a financial administrative penalty against a health plan company for violation of this subdivision when there is a pattern of abuse that demonstrates a lack of good faith effort and a systematic failure of the health plan company to comply with this subdivision.

Sec. 5. Minnesota Statutes 2018, section 62Q.75, subdivision 3, is amended to read:

Subd. 3. **Claims filing.** (a) Unless otherwise provided by contract, by section 16A.124, subdivision 4a, or by federal law, the health care providers and facilities specified in subdivision 2 must submit their charges to a health plan company or third-party administrator within ~~six~~ 12 months from the date of service or the date the health care provider knew or was informed of the correct name and address of the responsible health plan company or third-party administrator, whichever is later. A health care provider or facility that does not make an initial submission of charges within the ~~six-month~~ 12-month period shall not be reimbursed for the charge and may not collect the charge from the recipient of the service or any other payer. The ~~six-month~~ 12-month submission requirement may be extended to ~~12~~ 18 months in cases where a health care provider or facility specified in subdivision 2 has determined and can substantiate that it has experienced a significant disruption to normal operations that materially affects the ability to conduct business in a normal manner and to submit claims on a timely basis. Any request by a health care provider or facility specified in subdivision 2 for an exception to a contractually defined claims submission timeline must be reviewed and acted upon by the health plan company within the same time frame as the contractually agreed upon claims filing timeline.

(b) This subdivision also applies to all health care providers and facilities that submit charges to workers' compensation payers for treatment of a workers' compensation injury compensable under chapter 176, or to reparation obligors for treatment of an injury compensable under chapter 65B.

Sec. 6. Minnesota Statutes 2018, section 62Q.75, subdivision 4, is amended to read:

Subd. 4. **Claims adjustment timeline.** (a) Once a clean claim, as defined in section 62Q.75, subdivision 1, has been paid, the contract must provide a 12-month deadline on all adjustments to and recoupments of the payment with the exception of payments related to coordination of benefits, subrogation, duplicate claims, retroactive terminations, and cases of fraud and abuse.

(b) No health plan company or third-party administrator shall negatively adjust or recoup a payment based on a fee schedule that was not in effect on the date of service for which the claim was submitted.

(c) No health plan company or third-party administrator shall audit claims older than 12 months.

~~(b) Paragraph (a) shall not~~ (d) This subdivision does not apply to pharmacy contracts entered into between or on behalf of health plan companies.

Sec. 7. Minnesota Statutes 2018, section 256B.0625, subdivision 31, is amended to read:

Subd. 31. **Medical supplies and equipment.** (a) Medical assistance covers medical supplies and equipment. Separate payment outside of the facility's payment rate shall be made for wheelchairs and wheelchair accessories for recipients who are residents of intermediate care facilities for the developmentally disabled. Reimbursement for wheelchairs and wheelchair accessories for ICF/DD recipients shall be subject to the same conditions and limitations as coverage for recipients who do not reside in institutions. A wheelchair purchased outside of the facility's payment rate is the property of the recipient.

(b) Vendors of durable medical equipment, prosthetics, orthotics, or medical supplies must enroll as a Medicare provider.

(c) When necessary to ensure access to durable medical equipment, prosthetics, orthotics, or medical supplies, the commissioner may exempt a vendor from the Medicare enrollment requirement if:

(1) the vendor supplies only one type of durable medical equipment, prosthetic, orthotic, or medical supply;

(2) the vendor serves ten or fewer medical assistance recipients per year;

(3) the commissioner finds that other vendors are not available to provide same or similar durable medical equipment, prosthetics, orthotics, or medical supplies; and

(4) the vendor complies with all screening requirements in this chapter and Code of Federal Regulations, title 42, part 455. The commissioner may also exempt a vendor from the Medicare enrollment requirement if the vendor is accredited by a Centers for Medicare and Medicaid Services approved national accreditation organization as complying with the Medicare program's supplier and quality standards and the vendor serves primarily pediatric patients.

(d) Durable medical equipment means a device or equipment that:

(1) can withstand repeated use;

(2) is generally not useful in the absence of an illness, injury, or disability; and

(3) is provided to correct or accommodate a physiological disorder or physical condition or is generally used primarily for a medical purpose.

(e) Electronic tablets may be considered durable medical equipment if the electronic tablet will be used as an augmentative and alternative communication system as defined under subdivision 31a, paragraph (a). To be covered by medical assistance, the device must be locked in order to prevent use not related to communication.

(f) Notwithstanding the requirement in paragraph (e) that an electronic tablet must be locked to prevent use not as an augmentative communication device, a recipient of waiver services may use an electronic tablet for a use not related to communication when the recipient has been authorized under the waiver to receive one or more additional applications that can be loaded onto the electronic tablet, such that allowing the additional use prevents the purchase of a separate electronic tablet with waiver funds.

(g) An order or prescription for medical supplies, equipment, or appliances must meet the requirements in Code of Federal Regulations, title 42, part 440.70.

(h) A managed care plan or county-based purchasing plan must follow the same periodic and quantity limits that are in place and required for durable medical equipment and supplies under the fee-for-service system administered by the commissioner.

Sec. 8. Minnesota Statutes 2018, section 256B.69, is amended by adding a subdivision to read:

Subd. 6e. **Provider payments.** (a) Effective January 1, 2021, any managed care plan or county-based purchasing plan that contracts with the commissioner to provide covered services pursuant to this section must follow the same requirements for the submission and

payment of provider claims as are required by the commissioner under the fee-for-service system.

(b) Effective January 1, 2021, any managed care plan or county-based purchasing plan that contracts with the commissioner to provide covered services pursuant to this section must reimburse providers who are employed by or under contract with the plan an amount that is at least as much as the fee-for-service payment for the same covered service. Quality measures that must be tracked in conjunction with this paragraph include the rate of access to these services.