2025 Legislative Session

MNASCA Annual Conference

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Government Relations

2025 in Recap

- Poul Haas MNASCA Video

2025 Legislative Session – What Passed

- Reinsurance
- MN Care eligibility for undocumented adults
- Certification requirements for Central Service Technicians
- Facility fees reporting requirement
- Scope of Practice
  - Foreign medical practice licensure
  - Physician assistants' collaborative agreement
  - Optometrists scope expansion
- Prescription Drug Formularies

- Insurance Regulations/Coverage
  - External review of insurance denials
  - Audio only telehealth coverage
- Limits to insurance coverage
  - Physical therapy
  - Occupational therapy
  - Chiropractic care
- Patient notification
  - Explanation of benefits (EOB) delivered electronically
  - Non opioid directive authority
  - Written consent for "sensitive examinations"
- Workforce/HR
  - Paid Leave (PFML)
  - Earned Sick and Safe Time (ESST)
  - Labor Standards for rest and meal breaks

2025 Legislative Session – What Didn't Pass

- Provider tax increase
- Price transparency enforcement
- Health care provider immunity
- Accountability for prior authorization denials
- Prohibition of private equity investments in health care
- Transparency requirements in ownership of health care entities
- Restrictions on the corporate practice of medicine
- Medical Assistance reimbursement rates for outpatient facilities

2026 Legislative Session

- Session will start February 17, 2026
- Non budget year – policy focused
- State fiscal picture
- Election Year for constitutional officers
  - All MN House and Senate members
- Retirements

2026 Legislative Session – Potential Issues

- Provider Tax
- Artificial Intelligence (A/I) In healthcare decisions (particularly insurance or prior authorization)
- Transparency in Healthcare ownership
- Restrictions in the corporate practice of medicine
- Authorization of anesthesia assistants
- Accountability for Prior Authorization Denials
- Medical Malpractice Reform
  - Non-economic Damage Cap
  - Statute of limitations
- Medical Assistance Reimbursement Increase for outpatient procedures
- Prior Authorization Reform
  - Prior Authorization Reform from 2024 effective 1/26

Prior Authorization Reform

Effective January 1, 2026

Prior Authorization will no longer be required for:

- Outpatient substance use disorder or outpatient mental health treatment (except for treatment which is a medication)
- Antineoplastic cancer treatment that is consistent with guidelines of the National Comprehensive Cancer Network
- Services currently rated A or B by the United State Preventative Services Taskforce and recommended by the Advisory Committee on Immunization Practices (CDC)
- Pediatric hospice services
- Treatment delivered through a neonatal abstinence program operated by pediatric pain or palliative care specialist

Additional PA Reforms:

- Treatment for a chronic Condition
  - Chronic Condition (Expected to last 1 year or more)
    - <u>Authorization does not expire unless standard of treatment changes</u>
    - <u>Ongoing treatment needed to effectively manage condition</u>
- Health carrier **may not retroactively deny** services for which prior authorization (PA) was not required by the health carrier
- Health plans cannot deny coverage for a service an enrollee already received **solely because of a lack of PA if the service would have been covered** had PA not been obtained

Clinical Criteria Change

- Prior authorization does not apply if a utilization review organization changes coverage terms for a service or the clinical criteria used to conduct prior authorizations for a service when an independent source of research, clinical guidelines, or evidence-based standards has recommended changes in usage of the service for reasons related to previously unknown and imminent patient harm.

Annual Report to Commissioner of Health; Prior Authorizations

On or before September 1 each year, each utilization review organization must report to the commissioner of health, in a form and manner specified by the commissioner, information on prior authorization requests for the previous calendar year. The report submitted under this subdivision must include the following data:

- The total number of prior authorization requests received;
- The number of prior authorization requests for which an authorization was issued;
- The number of prior authorization requests for which an adverse determination was;
- The number of adverse determinations reversed on appeal;
- The 25 codes with the highest number of prior authorization requests and the percentage of authorizations for each of these codes;
- The 25 codes with the highest percentage of prior authorization requests for which an authorization was issued and the total number of the requests;

Annual Report to Commissioner of Health; Prior Authorizations

- The 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued but which was reversed on appeal and the total number of the requests;
- The 25 codes with the highest percentage of prior authorization requests for which an adverse determination was issued and the total number of the requests; and
- The reasons an adverse determination to a prior authorization request was issued, expressed as a percentage of all adverse determinations. The reasons listed may include but are not limited to:
  - The patient did not meet prior authorization criteria;
  - Incomplete information was submitted by the provider to the utilization review organization;
  - The treatment program changed; and
  - The patient is no longer covered by the health benefit plan

Technology Interface

- There is a new requirement for URO, Health Plan Companies, and Claim Administrators to have and maintain a PA application programming interface (API) that automates the PA process for healthcare services. This requirement goes into effect **on January 1, 2027**.

Healthcare Task Forces

- Healthcare Affordability Advisory Task Force
  - Consumer Advocates, Employers, Health Care Purchasers and Health Care Policy Experts
  - Develop Policy recommendations and affordability initiatives grounded in needs of those accessing/paying for health care
    - Analyze spending trends
    - Explore cost drivers
    - Evaluate options and recommend solutions

- Provider and Payer Advisory Task Force
  - Health Systems, Hospitals, Provider Groups, Safety Net Providers, Insurers, Pharmacists, PMS Health Plan Associations
  - Shape/Inform strategies into delivery, operational challenges, patients impacts, evaluate innovation, support affordability

2026 MNASCA Day at the Capitol

- We are currently planning this and look forward to sharing more soon

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