# SENATE
## STATE OF MINNESOTA
## EIGHTY-SEVENTH LEGISLATURE

# S.F. No. 1467

(SENATE AUTHORS: BERGLIN and Lourey)

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 05/22/2011 | 3259 | Introduction and first reading<br>Referred to Health and Human Services |

A bill for an act

relating to human services; reducing the administrative costs to managed care plans and county-based purchasing plans under the medical assistance program and the administrative payments to third-party administrators that administer the state employee group insurance plan; modifying personal care assistance services; creating a withhold to managed care plans and county-based purchasing plans for reducing hospitalizations; modifying the emergency room utilization rate withhold to managed care plans; delaying capitation payments for single adults without children in MinnesotaCare; creating demonstration projects for the delivery of health care services to certain medical assistance populations; limiting home and community-based waiver services allocations; requiring the commissioner of human services to issue a request for proposals to provide claims processing services for the fee-for-service medical assistance program; amending Minnesota Statutes 2010, sections 43A.23, subdivision 1; 256B.0625, subdivision 19a; 256B.0652, subdivision 6; 256B.69, subdivisions 5a, 5i, 28; 256L.12, subdivision 9; Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended.

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

Section 1. Minnesota Statutes 2010, section 43A.23, subdivision 1, is amended to read:

Subdivision 1. **General.** (a) The commissioner is authorized to request proposals or to negotiate and to enter into contracts with parties which in the judgment of the commissioner are best qualified to provide service to the benefit plans. Contracts entered into are not subject to the requirements of sections 16C.16 to 16C.19. The commissioner may negotiate premium rates and coverage. The commissioner shall consider the cost of the plans, conversion options relating to the contracts, service capabilities, character, financial position, and reputation of the carriers, and any other factors which the commissioner deems appropriate. Each benefit contract must be for a uniform term of at least one year, but may be made automatically renewable from term to term in the absence

of notice of termination by either party. A carrier licensed under chapter 62A is exempt from the taxes imposed by chapter 297I on premiums paid to it by the state.

(b) All self-insured hospital and medical service products must comply with coverage mandates, data reporting, and consumer protection requirements applicable to the licensed carrier administering the product, had the product been insured, including chapters 62J, 62M, and 62Q. Any self-insured products that limit coverage to a network of providers or provide different levels of coverage between network and nonnetwork providers shall comply with section 62D.123 and geographic access standards for health maintenance organizations adopted by the commissioner of health in rule under chapter 62D.

(c) Notwithstanding paragraph (b), a self-insured hospital and medical product offered under sections 43A.22 to 43A.30 is not required to extend dependent coverage to an eligible employee's unmarried child under the age of 25 to the full extent required under chapters 62A and 62L. Dependent coverage must, at a minimum, extend to an eligible employee's unmarried child who is under the age of 19 or an unmarried child under the age of 25 who is a full-time student. A person who is at least 19 years of age but who is under the age of 25 and who is not a full-time student must be permitted to be enrolled as a dependent of an eligible employee until age 25 if the person:

(1) was a full-time student immediately prior to being ordered into active military service, as defined in section 190.05, subdivision 5b or 5c;

(2) has been separated or discharged from active military service; and

(3) would be eligible to enroll as a dependent of an eligible employee, except that the person is not a full-time student.

The definition of "full-time student" for purposes of this paragraph includes any student who by reason of illness, injury, or physical or mental disability as documented by a physician is unable to carry what the educational institution considers a full-time course load so long as the student's course load is at least 60 percent of what otherwise is considered by the institution to be a full-time course load. Any notice regarding termination of coverage due to attainment of the limiting age must include information about this definition of "full-time student."

(d) Beginning January 1, 2010, the health insurance benefit plans offered in the commissioner's plan under section 43A.18, subdivision 2, and the managerial plan under section 43A.18, subdivision 3, must include an option for a health plan that is compatible with the definition of a high-deductible health plan in section 223 of the United States Internal Revenue Code.

(e) Beginning January 1, 2011, any contract entered into by the commissioner with a licensed carrier or third-party administrator to administer the health insurance benefit

plans offered under sections 43A.22 to 43A.30 shall reflect a reduction in administrative costs that equals a per enrollee per month reduction of 21 cents.

Sec. 2. Minnesota Statutes 2010, section 256B.0625, subdivision 19a, is amended to read:

Subd. 19a. **Personal care assistance services.** Medical assistance covers personal care assistance services in a recipient's home. Effective January 1, 2010, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in one activity of daily living as defined in section 256B.0659, subdivision 1, paragraph (b), or in a Level I behavior as defined in section 256B.0659, subdivision 1, paragraph (c). ~~Beginning July 1, 2011, to qualify for personal care assistance services, a recipient must require assistance and be determined dependent in at least two activities of daily living as defined in section 256B.0659.~~ Recipients or responsible parties must be able to identify the recipient's needs, direct and evaluate task accomplishment, and provide for health and safety. Approved hours may be used outside the home when normal life activities take them outside the home. To use personal care assistance services at school, the recipient or responsible party must provide written authorization in the care plan identifying the chosen provider and the daily amount of services to be used at school. Total hours for services, whether actually performed inside or outside the recipient's home, cannot exceed that which is otherwise allowed for personal care assistance services in an in-home setting according to sections 256B.0651 to 256B.0656. Medical assistance does not cover personal care assistance services for residents of a hospital, nursing facility, intermediate care facility, health care facility licensed by the commissioner of health, or unless a resident who is otherwise eligible is on leave from the facility and the facility either pays for the personal care assistance services or forgoes the facility per diem for the leave days that personal care assistance services are used. All personal care assistance services must be provided according to sections 256B.0651 to 256B.0656. Personal care assistance services may not be reimbursed if the personal care assistant is the spouse or paid guardian of the recipient or the parent of a recipient under age 18, or the responsible party or the family foster care provider of a recipient who cannot direct the recipient's own care unless, in the case of a foster care provider, a county or state case manager visits the recipient as needed, but not less than every six months, to monitor the health and safety of the recipient and to ensure the goals of the care plan are met. Notwithstanding the provisions of section 256B.0659, the unpaid guardian or conservator of an adult, who is not the responsible party and not the personal care provider organization, may be reimbursed to provide personal care assistance services to the recipient if the guardian or

conservator meets all criteria for a personal care assistant according to section 256B.0659, and shall not be considered to have a service provider interest for purposes of participation on the screening team under section 256B.092, subdivision 7.

Sec. 3. Minnesota Statutes 2010, section 256B.0652, subdivision 6, is amended to read:

Subd. 6. **Authorization; personal care assistance and qualified professional.** (a) All personal care assistance services, supervision by a qualified professional, and additional services beyond the limits established in subdivision 11, must be authorized by the commissioner or the commissioner's designee before services begin except for the assessments established in subdivision 11 and section 256B.0911. The authorization for personal care assistance and qualified professional services under section 256B.0659 must be completed within 30 days after receiving a complete request.

(b) The amount of personal care assistance services authorized must be based on the recipient's home care rating. The home care rating shall be determined by the commissioner or the commissioner's designee based on information submitted to the commissioner identifying the following for recipients with dependencies in two or more activities of daily living:

(1) total number of dependencies of activities of daily living as defined in section 256B.0659;

(2) presence of complex health-related needs as defined in section 256B.0659; and

(3) presence of Level I behavior as defined in section 256B.0659.

(c) For persons meeting the criteria in paragraph (b), the methodology to determine total time for personal care assistance services for each home care rating is based on the median paid units per day for each home care rating from fiscal year 2007 data for the personal care assistance program. Each home care rating has a base level of hours assigned. Additional time is added through the assessment and identification of the following:

(1) 30 additional minutes per day for a dependency in each critical activity of daily living as defined in section 256B.0659;

(2) 30 additional minutes per day for each complex health-related function as defined in section 256B.0659; and

(3) 30 additional minutes per day for each behavior issue as defined in section 256B.0659, subdivision 4, paragraph (d).

(d) Effective July 1, 2011, the home care rating for recipients who have a dependency in one activity of daily living or level one behavior shall equal no more than two units per

day. Recipients with this home care rating are not subject to the methodology in paragraph (c), and are not eligible for more than two units per day.

(e) A limit of 96 units of qualified professional supervision may be authorized for each recipient receiving personal care assistance services. A request to the commissioner to exceed this total in a calendar year must be requested by the personal care provider agency on a form approved by the commissioner.

Sec. 4. Minnesota Statutes 2010, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis beginning January 1, 1996. Managed care contracts which were in effect on June 30, 1995, and set to renew on July 1, 1995, shall be renewed for the period July 1, 1995 through December 31, 1995 at the same terms that were in effect on June 30, 1995. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A prepaid health plan providing covered health services for eligible persons pursuant to chapters 256B and 256L is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B and 256L established after the effective date of a contract with the commissioner take effect when the contract is next issued or renewed.

(c) Effective for services rendered on or after January 1, 2003, the commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the

contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

(d) Effective for services rendered on or after January 1, 2009, through December 31, 2009, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(e) Effective for services provided on or after January 1, 2010, the commissioner shall require that managed care plans use the assessment and authorization processes, forms, timelines, standards, documentation, and data reporting requirements, protocols, billing processes, and policies consistent with medical assistance fee-for-service or the Department of Human Services contract requirements consistent with medical assistance fee-for-service or the Department of Human Services contract requirements for all personal care assistance services under section 256B.0659.

(f) Effective for services rendered on or after January 1, 2010, through December 31, 2010, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

(g) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency room utilization rate for state health care program enrollees by a measurable rate of ten percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan demonstrates to the satisfaction of the commissioner that ~~a~~ this reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care

program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. ~~The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~ The withhold in this paragraph does not apply to county-based purchasing plans.

(h) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for hospitalizations for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for state health care program enrollees for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved.

The withhold described in this paragraph shall continue for three consecutive contract periods. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

~~(h)~~ (i) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(i)~~ (j) Effective for services rendered on or after January 1, 2012, through December 31, 2012, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(j)~~ (k) Effective for services rendered on or after January 1, 2013, through December 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692

for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(k)~~ (l) Effective for services rendered on or after January 1, 2014, the commissioner shall withhold three percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year. The commissioner may exclude special demonstration projects under subdivision 23.

~~(l)~~ (m) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

~~(m)~~ (n) Contracts between the commissioner and a prepaid health plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

~~(n)~~ (o) The return of the withhold under paragraphs (d), (f), and (h) to (k) is not subject to the requirements of paragraph (c).

Sec. 5. Minnesota Statutes 2010, section 256B.69, subdivision 5i, is amended to read:

Subd. 5i. **Administrative expenses.** (a) Managed care plan and county-based purchasing plan administrative costs for a prepaid health plan provided under this section or section 256B.692 must not exceed by more than five percent that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue. The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.

(b) Expenses listed under section 62D.12, subdivision 9a, clause (4), are not allowable administrative expenses for rate-setting purposes under this section, unless approved by the commissioner.

(c) Notwithstanding paragraph (a), the portion of the per member per month capitation rate paid under this section to managed care plans and county-based purchasing plans for administrative expenditures shall be reduced by 21 cents beginning July 1, 2011.

Sec. 6. Minnesota Statutes 2010, section 256B.69, subdivision 28, is amended to read:

Subd. 28. **Medicare special needs plans; medical assistance basic health care.** (a) The commissioner may contract with qualified Medicare-approved special needs plans to provide medical assistance basic health care services to persons with disabilities, including those with developmental disabilities. Basic health care services include:

(1) those services covered by the medical assistance state plan except for ICF/MR services, home and community-based waiver services, case management for persons with developmental disabilities under section 256B.0625, subdivision 20a, and personal care and certain home care services defined by the commissioner in consultation with the stakeholder group established under paragraph (d); and

(2) basic health care services may also include risk for up to 100 days of nursing facility services for persons who reside in a noninstitutional setting and home health services related to rehabilitation as defined by the commissioner after consultation with the stakeholder group.

The commissioner may exclude other medical assistance services from the basic health care benefit set. Enrollees in these plans can access any excluded services on the same basis as other medical assistance recipients who have not enrolled.

~~Unless a person is otherwise required to enroll in managed care, enrollment in these plans for Medicaid services must be voluntary. For purposes of this subdivision, automatic enrollment with an option to opt out is not voluntary enrollment.~~

(b) Beginning January 1, 2007, the commissioner may contract with qualified Medicare special needs plans to provide basic health care services under medical assistance to persons who are dually eligible for both Medicare and Medicaid and those Social Security beneficiaries eligible for Medicaid but in the waiting period for Medicare. The commissioner shall consult with the stakeholder group under paragraph (d) in developing program specifications for these services. The commissioner shall report to the chairs of the house of representatives and senate committees with jurisdiction over health and human services policy and finance by February 1, 2007, on implementation of these programs and the need for increased funding for the ombudsman for managed care and other consumer assistance and protections needed due to enrollment in managed care of persons with disabilities. Payment for Medicaid services provided under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

(c) Notwithstanding subdivision 4, beginning January 1, ~~2008~~ 2012, the commissioner ~~may expand contracting under this subdivision to all~~ shall enroll persons with disabilities ~~not otherwise required to enroll~~ in managed care under this section, unless the individual chooses to opt-out of enrollment. The commissioner shall establish

enrollment and opt out procedures consistent with applicable enrollment procedures under this subdivision.

(d) The commissioner shall establish a state-level stakeholder group to provide advice on managed care programs for persons with disabilities, including both MnDHO and contracts with special needs plans that provide basic health care services as described in paragraphs (a) and (b). The stakeholder group shall provide advice on program expansions under this subdivision and subdivision 23, including:

(1) implementation efforts;

(2) consumer protections; and

(3) program specifications such as quality assurance measures, data collection and reporting, and evaluation of costs, quality, and results.

(e) Each plan under contract to provide medical assistance basic health care services shall establish a local or regional stakeholder group, including representatives of the counties covered by the plan, members, consumer advocates, and providers, for advice on issues that arise in the local or regional area.

(f) The commissioner is prohibited from providing the names of potential enrollees to health plans for marketing purposes. The commissioner may mail marketing materials to potential enrollees on behalf of health plans, in which case the health plans shall cover any costs incurred by the commissioner for mailing marketing materials.

Sec. 7. Minnesota Statutes 2010, section 256L.12, subdivision 9, is amended to read:

Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita, where possible. The commissioner may allow health plans to arrange for inpatient hospital services on a risk or nonrisk basis. The commissioner shall consult with an independent actuary to determine appropriate rates.

(b) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care plan payments and county-based purchasing plan payments under this section pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan performance across a broader range of administrative services. The performance targets must include measurement of plan

efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, such as characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if performance targets in the contract are achieved.

(c) For services rendered on or after January 1, 2011, the commissioner shall withhold an additional three percent of managed care plan or county-based purchasing plan payments under this section. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year. The return of the withhold under this paragraph is not subject to the requirements of paragraph (b).

(d) Effective for services rendered on or after January 1, 2011, through December 31, 2011, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of five percent from the plan's utilization rate for the previous calendar year. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's emergency room utilization rate for state health care program enrollees by a measurable rate of ten percent from the plan's utilization rate for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan demonstrates to the satisfaction of the commissioner that ~~a~~ this reduction in the utilization rate was achieved.

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for state health care program enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved. ~~The commissioner shall structure the withhold so that the commissioner returns a portion of the withheld funds in amounts commensurate with achieved reductions in utilization less than the targeted amount.~~ The withhold described in this paragraph does not apply to county-based purchasing plans.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for state health care program enrollees by

a measurable rate of five percent from the plan's hospitalization rate for the previous calendar year.

The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following calendar year if the managed care plan or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was achieved.

The withhold described in this paragraph shall continue for three consecutive contract periods. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

~~(e)~~ (f) A managed care plan or a county-based purchasing plan under section 256B.692 may include as admitted assets under section 62D.044 any amount withheld under this section that is reasonably expected to be returned.

Sec. 8. Laws 2009, chapter 79, article 13, section 3, subdivision 8, as amended by Laws 2009, chapter 173, article 2, section 1, subdivision 8, Laws 2010, First Special Session chapter 1, article 15, section 5, and Laws 2010, First Special Session chapter 1, article 25, section 16, is amended to read:

Subd. 8. **Continuing Care Grants**

The amounts that may be spent from the appropriation for each purpose are as follows:

| | | |
|---|---|---|
| **(a) Aging and Adult Services Grants** | 13,499,000 | 15,805,000 |
| **Base Adjustment.** The general fund base is increased by $5,751,000 in fiscal year 2012 and $6,705,000 in fiscal year 2013. | | |
| **Information and Assistance Reimbursement.** Federal administrative reimbursement obtained from information and assistance services provided by the Senior LinkAge or Disability Linkage lines to people who are identified as eligible for medical assistance shall be appropriated to the commissioner for this activity. | | |
| **Community Service Development Grant Reduction.** Funding for community service | | |

development grants must be reduced by $260,000 for fiscal year 2010; $284,000 in fiscal year 2011; $43,000 in fiscal year 2012; and $43,000 in fiscal year 2013. Base level funding shall be restored in fiscal year 2014.

**Community Service Development Grant Community Initiative.** Funding for community service development grants shall be used to offset the cost of aging support grants. Base level funding shall be restored in fiscal year 2014.

**Senior Nutrition Use of Federal Funds.** For fiscal year 2010, general fund grants for home-delivered meals and congregate dining shall be reduced by $500,000. The commissioner must replace these general fund reductions with equal amounts from federal funding for senior nutrition from the American Recovery and Reinvestment Act of 2009.

| | | |
|---|---|---|
| **(b) Alternative Care Grants** | 50,234,000 | 48,576,000 |

**Base Adjustment.** The general fund base is decreased by $3,598,000 in fiscal year 2012 and $3,470,000 in fiscal year 2013.

**Alternative Care Transfer.** Any money allocated to the alternative care program that is not spent for the purposes indicated does not cancel but must be transferred to the medical assistance account.

| | | |
|---|---|---|
| **(c) Medical Assistance Grants; Long-Term Care Facilities.** | 367,444,000 | 419,749,000 |
| **(d) Medical Assistance Long-Term Care Waivers and Home Care Grants** | 853,567,000 | 1,039,517,000 |

**Manage Growth in TBI and CADI Waivers.** During the fiscal years beginning

on July 1, 2009, and July 1, 2010, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the TBI waiver to 12.5 allocations per month each year of the biennium and the CADI waiver to 95 allocations per month each year of the biennium. Limits do not apply: (1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure; (2) to fiscal year 2009 waiver allocations delayed due to unallotment; or (3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of "CS," "MT," or "HL." Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

**Manage Growth in DD Waiver.** The commissioner shall manage the growth in the DD waiver by limiting the allocations included in the February 2009 forecast to 15 additional diversion allocations each month for the calendar years that begin on January 1, 2010, and January 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care program of individuals having a home care rating of "CS," "MT," or "HL."

**Adjustment to Lead Agency Waiver Allocations.** Prior to the availability of the alternative license defined in Minnesota Statutes, section 245A.11, subdivision 8, the commissioner shall reduce lead agency waiver allocations for the purposes of implementing a moratorium on corporate foster care.

~~**Alternatives to Personal Care Assistance Services.** Base level funding of $3,237,000 in fiscal year 2012 and $4,856,000 in fiscal year 2013 is to implement alternative services to personal care assistance services for persons with mental health and other behavioral challenges who can benefit from other services that more appropriately meet their needs and assist them in living independently in the community. These services may include, but not be limited to, a 1915(i) state plan option.~~

**(e) Mental Health Grants**

| | Appropriations by Fund | |
|---|---|---|
| General | 77,739,000 | 77,739,000 |
| Health Care Access | 750,000 | 750,000 |
| Lottery Prize | 1,508,000 | 1,508,000 |

**Funding Usage.** Up to 75 percent of a fiscal year's appropriation for adult mental health grants may be used to fund allocations in that portion of the fiscal year ending December 31.

| | | |
|---|---|---|
| **(f) Deaf and Hard-of-Hearing Grants** | 1,930,000 | 1,917,000 |
| **(g) Chemical Dependency Entitlement Grants** | 111,303,000 | 122,822,000 |

**Payments for Substance Abuse Treatment.** For placements beginning during fiscal years 2010 and 2011, county-negotiated rates and

provider claims to the consolidated chemical dependency fund must not exceed the lesser of:

(1) rates charged for these services on January 1, 2009; ~~and~~ or

(2) 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Rates for fiscal years 2010 and 2011 must not exceed 160 percent of the average rate on January 1, 2009, for each group of vendors with similar attributes.

Effective July 1, 2010, rates that were above the average rate on January 1, 2009, are reduced by five percent from the rates in effect on June 1, 2010. Rates below the average rate on January 1, 2009, are reduced by 1.8 percent from the rates in effect on June 1, 2010. Services provided under this section by state-operated services are exempt from the rate reduction. For services provided in fiscal years 2012 and 2013, the statewide aggregate payment under the new rate methodology to be developed under Minnesota Statutes, section 254B.12, must not exceed the projected aggregate payment under the rates in effect for fiscal year 2011 excluding the rate reduction for rates that were below the average on January 1, 2009, plus a state share increase of $3,787,000 for fiscal year 2012 and $5,023,000 for fiscal year 2013. Notwithstanding any provision to the contrary in this article, this provision expires on June 30, 2013.

**Chemical Dependency Special Revenue Account.** For fiscal year 2010, $750,000 must be transferred from the consolidated chemical dependency treatment fund administrative account and deposited into the general fund.

**County CD Share of MA Costs for ARRA Compliance.** Notwithstanding the provisions of Minnesota Statutes, chapter 254B, for chemical dependency services provided during the period October 1, 2008, to December 31, 2010, and reimbursed by medical assistance at the enhanced federal matching rate provided under the American Recovery and Reinvestment Act of 2009, the county share is 30 percent of the nonfederal share. This provision is effective the day following final enactment.

| | | |
|---|---|---|
| **(h) Chemical Dependency Nonentitlement Grants** | 1,729,000 | 1,729,000 |
| **(i) Other Continuing Care Grants** | 19,201,000 | 17,528,000 |

**Base Adjustment.** The general fund base is increased by $2,639,000 in fiscal year 2012 and increased by $3,854,000 in fiscal year 2013.

**Technology Grants.** $650,000 in fiscal year 2010 and $1,000,000 in fiscal year 2011 are for technology grants, case consultation, evaluation, and consumer information grants related to developing and supporting alternatives to shift-staff foster care residential service models.

**Other Continuing Care Grants; HIV Grants.** Money appropriated for the HIV drug and insurance grant program in fiscal

year 2010 may be used in either year of the biennium.

**Quality Assurance Commission.** Effective July 1, 2009, state funding for the quality assurance commission under Minnesota Statutes, section 256B.0951, is canceled.

Sec. 9. **CAPITATION PAYMENT DELAY.**

(a) The commissioner of human services shall delay the MinnesotaCare capitation payment due in May of 2013 to managed care plans for single adults without children eligible under Minnesota Statutes, section 256L.04, subdivision 7, until July of 2013.

(b) The commissioner of human services shall delay payments due in April of 2013 for medical assistance services provided under Minnesota Statutes, section 256B.69, subdivision 28, until after July 1, 2013.

Sec. 10. **HEALTH CARE DELIVERY SYSTEMS DEMONSTRATION PROJECT.**

Subdivision 1. **Implementation.** (a) The commissioner shall develop and authorize a demonstration project to test alternative and innovative health care delivery systems, including accountable care organizations that provide services to a specified patient population for an agreed-upon total cost of care payment arrangement in accordance with subdivision 4. The commissioner shall develop one request for proposals to provide services to the elderly population eligible for medical assistance, and one request for proposals to provide services to families and children eligible for medical assistance and the MinnesotaCare program.

(b) In developing the request for proposals, the commissioner shall:

(1) establish uniform statewide methods of forecasting utilization and cost of care for the specified populations, to be used by the commissioner for the health care delivery system projects;

(2) identify key indicators of quality, access, patient satisfaction, and other performance indicators that will be measured, in addition to indicators for measuring cost savings;

(3) allow maximum flexibility to encourage innovation and variation so that a variety of provider collaborations are able to become health care delivery systems; and

(4) establish quality standards for the delivery system demonstrations.

(c) To be eligible to participate in the demonstration project, a health care delivery system must:

(1) provide required covered services and care coordination to recipients enrolled in the demonstration project;

(2) establish a process to ensure the quality of care provided;

(3) in cooperation with counties and community social service agencies, coordinate the delivery of health care services with existing social services programs;

(4) provide a system for advocacy and consumer protection; and

(5) adopt innovative and cost-effective methods of care delivery and coordination, which may include the use of allied health professionals, telemedicine, patient educators, care coordinators, and community health workers.

(d) A health care delivery system demonstration may be formed by the following groups of providers of services and suppliers if they have established a mechanism for shared governance:

(1) professionals in group practice arrangements;

(2) networks of individual practices of professionals;

(3) partnerships or joint venture arrangements between hospitals and health care professionals;

(4) hospitals employing professionals; and

(5) other groups of providers of services and suppliers as the commissioner determines appropriate.

A managed care plan or county-based purchasing plan may participate in this demonstration in collaboration with one or more of the entities listed in clauses (1) to (5).

A health care delivery system may contract with a managed care plan or a county-based purchasing plan to provide administrative services, including the administration of a payment system using the payment methods approved by the commissioner for health care delivery systems.

(e) The commissioner may require a health care delivery system to enter into additional third-party contractual relationships for the assessment of risk and purchase of stop loss insurance or another form of insurance risk management related to the delivery of care described in paragraph (c).

Subd. 2. **Enrollment.** (a) The commissioner shall develop and authorize at least two demonstration projects: one for families and children eligible for medical assistance and MinnesotaCare; and one for individuals 65 years of age or older eligible for medical assistance.

(b) Eligible applicants and recipients shall enroll in a health care delivery system if a system serves the county in which the applicant or recipient resides. If more than one health care delivery system serves a county, the applicant or recipient may choose among the delivery systems. The commissioner shall assign an applicant or recipient to a health care delivery system if a health care delivery system is available and no choice has been made by the applicant or recipient.

Subd. 3. **Accountability.** (a) Health care delivery systems must accept responsibility for the quality of care based on standards established under subdivision 1, paragraph (b), clause (4), and the cost of care or utilization of services provided to its enrollees under subdivision 1, paragraph (b), clause (1).

(b) A health care delivery system may contract and coordinate with providers and clinics for the delivery of services and shall contract with community health clinics, federally qualified health centers, community mental health centers or programs, and rural clinics to the extent practicable.

Subd. 4. **Payment system.** (a) In developing a payment system for health care delivery systems, the commissioner shall establish a total cost of care benchmark to be paid for services provided to the recipients enrolled in a health care delivery system.

(b) The total cost of care payment system shall not exceed the payments made in fiscal year 2011 by the commissioner under fee-for-service or managed care for the delivery of services to the specified populations within the geographic area served by the health care delivery system minus five percent.

(c) The payment system developed under this section shall incorporate the withhold and performance target requirements in Minnesota Statutes, section 256B.69, subdivision 5a.

Sec. 11. **MANAGE GROWTH IN TRAUMATIC BRAIN INJURY AND COMMUNITY ALTERNATIVES FOR DISABLED INDIVIDUALS WAIVERS.**

During the fiscal years beginning July 1, 2011, and July 1, 2012, the commissioner shall allocate money for home and community-based waiver programs under Minnesota Statutes, section 256B.49, to ensure a reduction in state spending that is equivalent to limiting the caseload growth of the traumatic brain injury waiver to six allocations per month each year of the biennium and the community alternatives for disabled individuals waiver to 60 allocations per month. The limits do not apply:

(1) when there is an approved plan for nursing facility bed closures for individuals under age 65 who require relocation due to the bed closure;

(2) to fiscal year 2009 waiver allocations delayed due to unallotment; or

(3) to transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. Priorities for the allocation of funds must be for individuals anticipated to be discharged from institutional settings or who are at imminent risk of a placement in an institutional setting.

Sec. 12. **MANAGE GROWTH IN DEVELOPMENTAL DISABILITY (DD) WAIVER.**

The commissioner shall manage the growth in the developmental disability waiver by limiting the allocations included in the November 2010 forecast to six additional diversion allocations each month for the fiscal year that begins on July 1, 2011. Additional allocations must be made available for transfers authorized by the commissioner from the personal care assistance program of individuals having a home care rating of CS, MT, or HL. This provision is effective through June 30, 2013.

Sec. 13. **REQUEST FOR PROPOSALS; CLAIMS PROCESSING FOR FEE-FOR-SERVICE MEDICAL ASSISTANCE.**

(a) The commissioner of human services shall issue a request for proposal for a contract to provide claims processing services for the fee-for-service medical assistance program, excluding outpatient pharmacy services. The contractor must be able to:

(1) process provider claims in a timely manner and within state and federal requirements;

(2) provide electronic claims submission access for providers;

(3) validate claims data;

(4) file and reconcile claims;

(5) identify fraud and abuse;

(6) measure quality assurance and performance outcomes; and

(7) coordinate benefits on the front end of a claim.

(b) The commissioner shall enter into a contract for claims processing by January 1, 2012. Payment under the contract shall not exceed $1.75 on average per claim processed.

(c) The commissioner shall apply for any federal grants that may be available.

**EFFECTIVE DATE.** This section is effective the day following final enactment.