**CHAPTER 364–S.F.No. 3322**

*An act relating to human services; improving management of state health care programs; modifying managed care contracting; modifying county-based purchasing; requiring reports; amending Minnesota Statutes 2006, sections 13.461, by adding a subdivision; 256B.69, subdivision 5a, by adding subdivisions; 256B.692, subdivision 2, by adding a subdivision; 256L.12, subdivision 9; Laws 2005, First Special Session chapter 4, article 8, section 84, as amended.*

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

Section 1. Minnesota Statutes 2006, section 13.461, is amended by adding a subdivision to read:

Subd. 24a. **Managed care plans.** Data provided to the commissioner of human services by managed care plans relating to contracts and provider payment rates are classified under section 256B.69, subdivisions 9a and 9b.

Sec. 2. Minnesota Statutes 2006, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and sections 256L.12 and 256D.03, 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, 256D, and 256L, is responsible for complying with the terms of its contract with the commissioner. Requirements applicable to managed care programs under chapters 256B, 256D, 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 for the prepaid medical assistance and general assistance medical care programs 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

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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. 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 paragraph that is reasonably expected to be returned.

Sec. 3. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision 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.

Sec. 4. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 5j. **Treatment of investment earnings.** Capitation rates shall treat investment income and interest earnings as income to the same extent that investment-related expenses are treated as administrative expenditures.

Sec. 5. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 9a. **Administrative expense reporting.** Within the limit of available appropriations, the commissioner shall work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by managed care plans under section 62D.08 and county-based purchasing plans under section 256B.692, provided that such data are consistent with guidelines and standards for administrative spending that are developed by the commissioner of health, and reported to the legislature under section 12 of this act. Data provided to the commissioner under this subdivision are nonpublic data as defined under section 13.02.

**EFFECTIVE DATE.** This section is effective July 1, 2009.

Sec. 6. Minnesota Statutes 2006, section 256B.69, is amended by adding a subdivision to read:

Subd. 9b. **Reporting provider payment rates.** (a) According to guidelines developed by the commissioner, in consultation with managed care plans and county-based

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purchasing plans, each managed care plan and county-based purchasing plan must provide to the commissioner, at the commissioner's request, detailed or aggregate information on reimbursement rates paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to provider types and vendors for administrative services under contract with the plan.

(b) Data provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02.

**EFFECTIVE DATE.** This section is effective January 1, 2010.

Sec. 7. Minnesota Statutes 2006, section 256B.692, subdivision 2, is amended to read:

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. The county board of commissioners is the governing body of a county-based purchasing program. In a multicounty arrangement, the governing body is a joint powers board established under section 471.59.

(b) A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and, effective January 1, 2010, fiscal solvency of chapter 62D, applicable to health maintenance organizations~~, or chapter 62N, applicable to community integrated service networks,~~ will be met~~.~~ according to the following schedule:

(1) for a county-based purchasing plan approved on or before June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D as of January 1, 2010;

(ii) at least 75 percent of the minimum amount required under chapter 62D as of January 1, 2011;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D as of January 1, 2012; and

(iv) at least 100 percent of the minimum amount required under chapter 62D as of January 1, 2013; and

(2) for a county-based purchasing plan first approved after June 30, 2008, the plan must have in reserve:

(i) at least 50 percent of the minimum amount required under chapter 62D at the time the plan begins enrolling enrollees;

(ii) at least 75 percent of the minimum amount required under chapter 62D after the first full calendar year;

(iii) at least 87.5 percent of the minimum amount required under chapter 62D after the second full calendar year; and

(iv) at least 100 percent of the minimum amount required under chapter 62D after the third full calendar year.

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(c) Until a plan is required to have reserves equaling at least 100 percent of the minimum amount required under chapter 62D, the plan may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N. A ~~county~~ county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

(d) All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

(e) The commissioner, in consultation with county government, shall develop administrative and financial reporting requirements for county-based purchasing programs relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.28, 62N.29, and 62N.31, and other sections as necessary, that are specific to county administrative, accounting, and reporting systems and consistent with other statutory requirements of counties.

(f) The commissioner shall collect from a county-based purchasing plan under this section the following fees:

(1) fees attributable to the costs of audits and other examinations of plan financial operations. These fees are subject to the provisions of Minnesota Rules, part 4685.2800, subpart 1, item F;

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year, beginning in calendar year 2009; and

(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008.

All fees collected under this paragraph shall be deposited in the state government special revenue fund.

Sec. 8. Minnesota Statutes 2006, section 256B.692, is amended by adding a subdivision to read:

Subd. 4a. **Expenditure of revenues.** (a) A county that has elected to participate in a county-based purchasing plan under this section shall use any excess revenues over expenses that are received by the county and are not needed (1) for capital reserves under subdivision 2, (2) to increase payments to providers, or (3) to repay county investments or contributions to the county-based purchasing plan, for prevention, early intervention, and health care programs, services, or activities.

(b) A county-based purchasing plan under this section is subject to the unreasonable expense provisions of section 62D.19.

Sec. 9. Minnesota Statutes 2006, 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.

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(b) For services rendered on or after January 1, 2003, to December 31, 2003, the commissioner shall withhold .5 percent of managed care plan payments under this section pending completion of performance targets. The withheld funds must be returned no sooner than July 1 and no later than July 31 of the following year if performance targets in the contract are achieved. A managed care plan may include as admitted assets under section 62D.044 any amount withheld under this paragraph that is reasonably expected to be returned.

(c) For services rendered on or after January 1, 2004, the commissioner shall withhold five percent of managed care 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. 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 paragraph that is reasonably expected to be returned.

Sec. 10. Laws 2005, First Special Session chapter 4, article 8, section 84, as amended by Laws 2006, chapter 264, section 15, is amended to read:

Sec. 84. **[256B.694] SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.**

(a) Notwithstanding Minnesota Statutes, section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. ~~The commissioner shall continue single health plan purchasing arrangements with county-based purchasing entities in the service areas in existence on May 1, 2006, including arrangements for which a proposal was submitted by May 1, 2006, on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena Counties, in response to a request for proposals issued by the commissioner.~~ The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's

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next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) The commissioner shall consider, and may approve, contracting on a single-health plan basis with other county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons with a disability who voluntarily enroll, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in Minnesota Statutes, section 256B.69, subdivision 23, are satisfied. ~~By January 15, 2007, the commissioner shall report to the chairs of the appropriate legislative committees in the house and senate an analysis of the advantages and disadvantages of using single-health plan purchasing to serve persons with a disability who are eligible for health care programs. The report shall include consideration of the impact of federal health care programs and policies for persons who are eligible for both federal and state health care programs and shall consider strategies to improve coordination between federal and state health care programs for those persons.~~ Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

Sec. 11. **REPORT ON FINANCIAL MANAGEMENT OF HEALTH CARE PROGRAMS.**

Within the limits of available appropriations, the commissioner of human services shall report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with the following information regarding financial management of health care programs:

(1) a status report on implementation of the cost containment strategies identified in the 2005 "Strategies for Savings" report. The report must include:

(i) information on progress made towards implementation of cost-saving strategies;

(ii) an explanation of why certain strategies were not implemented; and

(iii) where appropriate, alternative strategies to those recommended in 2005 for containing public health care program costs;

(2) a description of and, to the extent possible, an explanation of recent differences between the health plan net revenue targets established by the commissioner for health plans participating in public health care programs and the actual net revenue realized by the plans from public programs;

(3) the adequacy of public health care program for fee-for-service rates, including an identification of service areas or geographical regions where enrollees have difficulty accessing providers as the result of inadequate provider payments. This report must include recommendations to increase rates as needed to eliminate identified access problems; and

(4) a progress report on implementation of Minnesota Statutes, section 256B.76, paragraph (e), requiring payments for physician and professional services to be based on Medicare relative value units, and an estimated completion date for implementation of this payment system.

Sec. 12. **HEALTH PLAN AND COUNTY-BASED PURCHASING PLAN REQUIREMENTS.**

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The commissioner of health shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, guidelines to ensure that health plans, and county-based purchasing plans where applicable, have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs. The guidelines shall be consistent with generally accepted accounting principles and principles from the National Association of Insurance Commissioners. The guidelines shall not have the effect of changing allocation for Medicare-related programs as permitted by federal law and the Centers for Medicare and Medicaid Services. The report shall include recommendations and cost estimates for developing detailed standards and procedures for examining the reasonableness of health plan and county-based purchasing plan administrative expenditures for publicly funded programs. These standards and procedures must include a process for detailed examinations of individual programs and functional areas.

Sec. 13. **OMBUDSMAN FOR MANAGED CARE STUDY.**

Within the limits of available appropriations, the commissioner of human services, in cooperation with the ombudsman for managed care, shall study and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with recommendations on whether the duties of the ombudsman should be expanded to include advocating on behalf of public health care program fee-for-service enrollees. The report must include:

(1) a comparison of the recourse available to managed care clients versus fee-for-service clients when service problems occur; and

(2) an estimate of any net cost increase from this change in the ombudsman's duties, taking into account any reduction in the commissioner's duties.

Sec. 14. **REPORTING MANAGED CARE PERFORMANCE DATA.**

The commissioner of human services, in cooperation with the commissioner of health, shall report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, with recommendations on the adoption of a single method to compute and publicly report managed health care performance measures in order to avoid confusion about the plans' performance levels. The study must include recommendations regarding coordinated use by the two agencies of the following data sources:

(1) Healthcare Effectiveness Data and Information Set (HEDIS) from managed care organizations;

(2) data that health plans submit to claim reimbursement for health care procedures; and

(3) data collected from medical record reviews of randomly selected individuals.

Sec. 15. **CREDENTIALING METHODOLOGY.**

The commissioner of human services shall explore the feasibility of using or coordinating with the credentialing collaborative between Minnesota payers, providers, and hospitals in order to make the provider enrollment process for Minnesota health care programs more efficient. By December 15, 2009, the commissioner shall inform the chairs of the senate and house of representatives policy committees and finance divisions with responsibility for human services of the results of these efforts.

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Sec. 16. **HEALTH MAINTENANCE ORGANIZATION RENEWAL FEE.**

The health maintenance organization renewal fee under Minnesota Rules, part 4685.2800, subpart 2, shall be increased by 14.6 cents from the level in effect on June 30, 2008, for the fiscal year beginning July 1, 2008. The renewal fee shall revert to its previous level for fiscal years beginning on or after July 1, 2009.

Sec. 17. **APPROPRIATIONS.**

(a) $261,000 is appropriated from the state government special revenue fund to the commissioner of health for the purposes of this act for fiscal year 2009. Base level funding for this appropriation shall be $77,000 for fiscal years beginning on or after July 1, 2009.

(b) Of the appropriation in paragraph (a), $116,000 in fiscal year 2009 is for the study and report required in section 12, $145,000 in fiscal year 2009 shall be transferred to the general fund, and $77,000 shall be transferred for each fiscal year beginning on or after July 1, 2009.

(c) $145,000 is appropriated from the general fund to the commissioner of human services for fiscal year 2009 for the actuarial and other department costs associated with additional reporting requirements for health plans and county-based purchasing plans. Base level funding for this appropriation for fiscal years beginning on or after July 1, 2009, shall be $135,000 each year.

(d) $96,000 is appropriated from the general fund to the commissioner of human services for fiscal year 2009 for the study authorized in section 11, clause (3). This appropriation is onetime.

Presented to the governor May 19, 2008

Signed by the governor May 23, 2008, 11:57 a.m.

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