CHAPTER 62P

REGULATED ALL-PAYER OPTION

62P.01 REGULATED ALL-PAYER OPTION.

The purpose of the regulated all-payer option is to provide an alternative to integrated service networks for those consumers, providers, third-party payers, and group purchasers who prefer to participate in a fee-for-service system. The initial goal of the all-payer option is to reduce administrative costs and burdens by including the all-payer option in a uniform, standardized system of billing forms and procedures and utilization review. The longer-term goal of the all-payer option is to establish a uniform reimbursement system, reimbursement and utilization controls, and quality standards and monitoring; to ensure that the annual growth in the costs for all services not provided through integrated service networks will remain within the growth limits established under section 62J.04; and to ensure that quality for these services is maintained or improved.

History: *1993 c 345 art 2 s 2; 1994 c 625 art 3 s 1*

62P.02 DEFINITIONS.

(a) For purposes of this chapter, the following definitions apply:

(b) "All-payer insurer" means a health carrier as defined in section 62A.011, subdivision 2. The term does not include community integrated service networks or integrated service networks licensed under chapter 62N.

(c) "All-payer reimbursement level" means the reimbursement amount specified by the all-payer reimbursement system.

(d) "All-payer reimbursement system" means the Minnesota-specific physician and independent provider fee schedule, the Minnesota-specific hospital reimbursement system, and other provider payment methods established under this chapter or rules adopted under this chapter.

(e) "Commissioner" means the commissioner of health.

(f) "Health care provider" has the meaning given in section 62J.03, subdivision 8.

History: *1994 c 625 art 3 s 2*

62P.03 IMPLEMENTATION.

On July 1, 1994, the regulated all-payer option shall begin to be phased in with full implementation of the all-payer reimbursement system by July 1, 1997. During the transition period, expenditure limits for health carriers shall be established in accordance with section 62P.04 and health care provider revenue limits shall be established in accordance with section 62P.05.

History: *1993 c 345 art 2 s 3; 1994 c 625 art 3 s 3*

62P.04 INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01.

(c) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues.

(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.

(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota comprehensive health association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, assessments by the Minnesota risk adjustment association, and any new assessments imposed by federal or state law.

(f) "Consumer cost-sharing or subscriber liability" means enrollee coinsurance, copayment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in net expenditures by each health carrier plan company for calendar years 1994, 1995, 1996, and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one expenditure limit for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the expenditure limits. No premium rate, currently reviewed by the departments of health or commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as an integrated service network or community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. **Notice.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health plan companies that exceeded their expenditure limit for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its expenditure limit, at least 30 days before publishing the list, and shall provide each health plan company with ten days to provide an explanation for exceeding the expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce. The commissioner of commerce, in consultation with the commissioner of health, shall enforce compliance with expenditure limits for those health plan companies.

Subd. 7. **Enforcement.** (a) The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health plan companies that each commissioner respectively regulates. Each commissioner shall require health plan companies under the commissioner's jurisdiction to submit plans of corrective action when the reserve requirement is not met. The plan of correction must address the following:

(1) actuarial assumptions used in forecasting future financial results;

(2) trend assumptions used in setting future premiums;

(3) demographic, geographic, and private and public sector mix of the population covered by the health plan company;

(4) proposed rate increases or decreases;

(5) growth limits applied under section 62J.04, subdivision 1, paragraph (b); and

(6) other factors deemed appropriate by the health plan company or commissioner.

If the health plan company's reserves exceed the required maximum, the plan of correction shall address how the health plan company will come into compliance and set forth a timetable within which compliance would be achieved. The plan of correction may propose premium refunds, credits for prior premiums paid, policyholder dividends, or any combination of these or other methods which will benefit enrollees and/or Minnesota residents and are such that the reserve requirements can reasonably be expected to be met. The commissioner's evaluation of the plan of correction must consider:

(1) whether implementation of the plan would provide the company with an unfair advantage in the market;

(2) the extent to which the reserve excess was created by any movement of enrolled persons to another organization formed by the company;

(3) whether any proposed premium refund, credit, and/or dividend represents an equitable allocation to policyholders covered in prior periods as determined using sound actuarial practice; and

(4) any other factors deemed appropriate by the applicable commissioner.

(b) The plan of correction is subject to approval by the commissioner of health or commerce, as applicable. If such a plan is not approved by the applicable commissioner, the applicable commissioner shall enter an order stating the steps that the health plan company must take to come into compliance. Within 30 days of the date of such order, the health plan company must file a notice of appeal with the applicable commissioner or comply with the commissioner's order. If an appeal is filed, such appeal is governed by chapter 14.

(c) Health plan companies that exceed the expenditure limits based on two-year average expenditure data (1994 and 1995, 1996 and 1997) shall be required by the appropriate commissioner to pay back the amount exceeding the expenditure limit through an assessment on the health plan company. A health plan company may appeal the commissioner's order to pay back the amount exceeding the expenditure limit by mailing to the commissioner a written notice of appeal within 30 days from the date the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The health plan company shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund. The appropriate commissioner may approve a different repayment method to take into account the health plan company's financial condition. Health plan companies shall comply with the limits but shall also guarantee that their contractual obligations are met. Health plan companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles and amounts in excess of benefit plan maximums.

History: *1993 c 345 art 2 s 4; 1994 c 625 art 3 s 4*

62P.05 HEALTH CARE PROVIDER REVENUE LIMITS.

Subdivision 1. **Definition.** For purposes of this section, "health care provider" has the definition given in section 62J.03, subdivision 8.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in revenue for each health care provider, for calendar years 1994, 1995, 1996,

and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). The commissioner may adjust final revenue figures for case mix complexity, payer mix, out-of-period settlements, certain taxes and assessments including the MinnesotaCare provider tax and provider surcharge, any new assessments imposed by federal or state law, research and education costs, donations, grants, and legislative initiatives that materially change health care revenues, as long as these adjustments are consistent with the methodology submitted by the health care provider to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by September 1, 1994. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 3. **Monitoring of revenue.** The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor hospital revenue by examining net inpatient revenue per adjusted admission and net outpatient revenue per outpatient visit. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. For purposes of this section, definitions related to the implementation of limits for providers other than hospitals are included in Minnesota Rules, chapter 4650, and definitions related to the implementation of limits for hospitals are included in Minnesota Rules, chapter 4651. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees.

Subd. 4. **Monitoring and enforcement.** Health care providers shall submit to the commissioner of health, in the form and at the times required by the commissioner, all information the commissioner determines to be necessary to implement and enforce this section. The commissioner shall regularly audit all health clinics employing or contracting with over 100 physicians. The commissioner shall also audit, at times and in a manner that does not interfere with delivery of patient care, a sample of smaller clinics and other health care providers. Providers that exceed revenue limits based on two-year average revenue data shall be required by the commissioner to pay back the amount exceeding the revenue limits during the following calendar year.

Pharmacists may adjust their revenue figures for increases in drug product costs that are set by the manufacturer. The commissioner shall consult with pharmacy groups, including pharmacies, wholesalers, drug manufacturers, health plans, and other interested parties, to determine the methodology for measuring and implementing the interim growth limits while taking into account the adjustments for drug product costs.

The commissioner shall monitor providers meeting the growth limits based on their current fees on an annual basis. The fee charged for each service must be based on a weighted average across 12 months and compared to the weighted average for the previous 12-month period. The percentage increase in the average fee from 1993 to 1994, from 1994 to 1995, from 1995 to 1996, and from 1996 to 1997 is subject to the growth limits established under section 62J.04, subdivision 1, paragraph (b). The audit process may include a review of the provider's monthly fee schedule, and a random claims analysis for the provider during different parts of the year to monitor variations in fees. The commissioner shall require providers that exceed growth limits, based on annual fees, to pay back during the following calendar year the amount of fees received exceeding the limit.

The commissioner shall notify each provider that has exceeded its revenue or fee limit, at least 30 days before taking action, and shall provide each provider with ten days to provide an explanation for exceeding the revenue or fee limit. The commis-

sioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

The commissioner may approve a different repayment schedule for a health care provider that takes into account the provider's financial condition.

A provider may appeal the commissioner's order to pay back the amount exceeding the revenue or fee limit by mailing a written notice of appeal to the commissioner within 30 days after the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The provider shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund.

History: *1993 c 345 art 2 s 5; 1Sp1993 c 6 s 38; 1994 c 625 art 3 s 5*

62P.07 SCOPE.

Subdivision 1. **General applicability.** (a) Minnesota health care providers shall comply with the requirements and rules established under this chapter for: (1) all health care services provided to Minnesota residents who are not enrolled in a community integrated service network or an integrated service network; (2) all out-of-network services provided to enrollees of community integrated service networks and integrated service networks; and (3) all health care services provided to persons covered by an all-payer insurer.

(b) All-payer insurers shall comply with the requirements and rules established under this chapter for all coverage provided.

(c) Community integrated service networks and integrated service networks shall comply with the requirements and rules established under this chapter when reimbursing health care providers for out-of-network services.

Subd. 2. **Programs excluded.** This chapter does not apply to services reimbursed under Medicare, medical assistance, general assistance medical care, the MinnesotaCare program, or workers' compensation programs.

Subd. 3. **Payment required at all-payer level.** (a) All reimbursements to Minnesota health care providers from all-payer insurers, for services provided to covered persons, shall be at the all-payer reimbursement level.

(b) All-payer insurers shall reimburse out-of-state health care providers for nonemergency services provided to covered persons at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency services" means services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

(c) Community integrated service networks and integrated service networks shall reimburse Minnesota health care providers for out-of-network services at the all-payer reimbursement level.

(d) Community integrated service networks and integrated service networks shall reimburse out-of-network health care providers located out of state for nonemergency out-of-network services at the all-payer reimbursement level. For purposes of this paragraph, "nonemergency out-of-network services" means out-of-network services that do not meet the definition of "emergency care" under Minnesota Rules, part 4685.0100, subpart 5.

Subd. 4. **Balance billing prohibited.** Minnesota health care providers shall accept reimbursement at the all-payer reimbursement level, including applicable copayments, deductibles, and coinsurance, as payment in full for services provided to Minnesota residents and persons covered by all-payer insurers, and for out-of-network services provided to enrollees of community integrated service networks and integrated service networks.

History: *1994 c 625 art 3 s 6*

62P.09 DUTIES OF THE COMMISSIONER.

Subdivision 1. **General duties.** The commissioner of health is responsible for developing and administering the all-payer option. The commissioner shall:

(1) develop, implement, and administer fee schedules for physicians and providers with independent billing rights;

(2) develop, implement, and administer a reimbursement system for hospitals and other institutional providers, but excluding intermediate care facilities for the mentally retarded, nursing homes, state-operated community service sites operated by the commissioner of human services, and regional treatment centers;

(3) modify and adjust all-payer reimbursement levels so that health care spending under the all-payer option does not exceed the growth limits on health care spending established under section 62J.04;

(4) collect data from all-payer insurers, health care providers, and patients to monitor revenues, spending, and quality of care;

(5) provide incentives for the appropriate utilization of services and the appropriate use and distribution of technology;

(6) coordinate the development and administration of the all-payer option with the development and administration of the integrated service network system; and

(7) develop and implement a fair and efficient system for resolving appeals by providers and insurers.

Subd. 2. **Coordination.** The commissioner shall regularly consult with the commissioner of commerce in developing and administering the all-payer option and in applying the all-payer reimbursement system to health carriers regulated by the commissioner of commerce.

Subd. 3. **Timelines for implementation.** In developing and implementing the all-payer option, the commissioner shall comply with the following implementation schedule:

(a) The phase-in of standardized billing requirements must be completed following the timetable set forth in sections 62J.50 to 62J.61 and Laws 1994, chapter 625, article 9, sections 13 to 15.

(b) The phase-in of the all-payer reimbursement system must begin January 1, 1996, or upon the date rules for the all-payer option reimbursement system are adopted, whichever is later.

(c) The all-payer reimbursement system must be fully implemented by July 1, 1997.

Subd. 4. **Advisory committee.** The commissioner shall convene an advisory committee made up of a broad array of health care professionals that will be affected by the fee schedule. Recommendations of this committee must be submitted to the commissioner by November 15, 1994, and may be incorporated in the implementation report due January 1, 1995.

Subd. 5. **Rulemaking.** The commissioner shall adopt rules to establish and administer the all-payer option. The rules must include, but are not limited to: (1) the reimbursement methods used in the all-payer option reimbursement system; (2) a plan and implementation schedule to phase in the all-payer reimbursement system, beginning January 1, 1996; and (3) mechanisms to ensure compliance by all-payer insurers, health care providers, and patients with the all-payer reimbursement system and the growth limits established under section 62J.04. The commissioner shall seek to ensure that the rules for the all-payer option are adopted by January 1, 1996. The commissioner shall comply with section 62J.07, subdivision 3, when adopting rules for the all-payer option.

History: *1994 c 625 art 3 s 7*

62P.11 PAYMENT TO PHYSICIANS AND INDEPENDENT PROVIDERS.

Subdivision 1. **Fee schedule.** The commissioner shall adopt a Minnesota-specific fee schedule, based upon the Medicare resource based relative value scale, to reimburse

physicians and other independent providers. The fee schedule must assign each service a relative value unit that measures the relative resources required to provide the service. Payment levels for each service must be determined by multiplying relative value units by a conversion factor that converts relative value units into monetary payment. The conversion factor used to derive the fee schedule must be set at a level that is consistent with current relevant health care spending, subject to the state's growth limits as defined in section 62J.04. The conversion factor must be set at a level that equalizes total aggregate expenditures for a given period before and after implementation of the all-payer option.

Subd. 2. **Development and modification of relative value units.** (a) When appropriate, the relative value unit for each service shall be the Medicare value adjusted to reflect Minnesota health care costs. The commissioner may assign a different relative value to a service if, in the judgment of the commissioner, the Medicare relative value unit is not accurate. The commissioner may also develop or adopt relative value units for services not covered under the Medicare resource based relative value scale. Except as provided in paragraph (b), modifications or additions to relative value units are subject to the rulemaking requirements of chapter 14.

(b) The commissioner may modify the relative value units used in the Minnesota-specific fee schedule, or change the number of services assigned relative value units, to reflect changes and improvements in the Medicare resource based relative value scale. When adopting these federal changes, the commissioner is exempt from the rulemaking requirements of chapter 14, but shall publish a notice of modifications and additions to relative value units in the State Register 30 days before they take effect.

Subd. 3. **Development of the conversion factor.** The commissioner shall develop a conversion factor using actual Minnesota claims data available to the commissioner.

History: *1994 c 625 art 3 s 8*

62P.13 VOLUME PERFORMANCE STANDARD FOR PHYSICIAN AND OUTPATIENT SERVICES.

Subdivision 1. **Development.** The commissioner shall establish an annual, statewide volume performance standard for physician and outpatient services. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with achieving the growth limits pursuant to section 62J.04. The volume performance standard must combine expenditures for all services provided by physicians and other independent providers and all ambulatory care services that are not provided through an integrated service network. The statewide volume performance standard must be developed from aggregate and encounter level data reported to the state, including the claims database established under section 62J.38, when it becomes operational.

Subd. 2. **Application.** The commissioner shall compare actual expenditures for physician and outpatient services with the volume performance standard in order to keep the all-payer option expenditures within the statewide growth limits. If total expenditures during a particular year exceed the expenditure target for that year, the commissioner shall update the fee schedule rates for the second year following the year in which the target was exceeded, by adjusting the conversion factor, in order to offset this increase.

History: *1994 c 625 art 3 s 9*

62P.15 REIMBURSEMENT.

The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor which health care professionals should be paid at the full fee schedule rate and which at a partial rate, for services covered in the fee schedule.

History: *1994 c 625 art 3 s 10*

62P.17 PAYMENT FOR SERVICES NOT IN THE FEE SCHEDULE.

The commissioner shall examine options for paying for services not covered in the fee schedule and shall present recommendations to the legislature and the governor as part of the implementation report due January 1, 1995. The options examined by the commissioner must include, but are not limited to, updates and modifications to the Medicare resource based relative value scale; development of additional relative value units; development of a fee schedule based on a percentage of usual, customary, and reasonable charges; and use of rate of increase controls.

History: *1994 c 625 art 3 s 11*

62P.19 PAYMENT FOR URBAN AND SELECTED RURAL HOSPITALS.

Subdivision 1. **Establishment of rate.** The commissioner shall develop a Minnesota-specific hospital reimbursement system to pay for inpatient services in those acute-care general hospitals not qualifying for reimbursement under section 62P.25. In developing this system, the commissioner shall consider the all-patient refined diagnosis related groups system and other diagnosis related groups systems. Payment rates must be standardized on a statewide basis based on Minnesota specific claims level data available to the commissioner. Rates must be consistent with the overall growth limit for health care spending. Payment rates may be adjusted for area wage rates and other factors, including uncompensated care. The commissioner shall recommend any needed adjustments to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. **Short stay and long stay outliers.** The reimbursement system must provide, on a budget neutral basis, lower charges for self-pay patients with short or low cost stays. The commissioner shall phase out this exception once universal coverage is achieved. The commissioner, as part of the implementation report due January 1, 1995, shall recommend to the legislature and the governor whether an outlier payment for long stays is needed.

History: *1994 c 625 art 3 s 12*

62P.21 STATEWIDE VOLUME PERFORMANCE STANDARD FOR HOSPITALS.

Subdivision 1. **Development.** The commissioner shall establish an annual, statewide volume performance standard for inpatient hospital expenditures. The volume performance standard shall serve as an expenditure target and must be set at a level that is consistent with meeting the limits on health care spending growth.

Subd. 2. **Application.** The commissioner shall compare actual inpatient hospital expenditures with the volume performance standard in order to keep all-payer option expenditures within the statewide growth limits. If aggregate inpatient hospital expenditures for a particular year exceed the volume performance standard, the commissioner shall adjust the annual increase in payment levels for the following year.

History: *1994 c 625 art 3 s 13*

62P.23 FLEXIBILITY IN APPLYING THE VOLUME PERFORMANCE STANDARD; REVIEW.

Subdivision 1. **Reallocation.** The commissioner may reallocate spending limits between the inpatient hospital services volume performance standard and the physician and outpatient services volume performance standard, if this promotes the efficient use of health care services and does not cause total health care spending in the all-payer option to exceed the level allowed by the growth limits on health care spending.

Subd. 2. **Review.** The commissioner shall review the effectiveness of the volume performance standard after the first three years of operation and shall recommend any necessary changes to the legislature and the governor.

History: *1994 c 625 art 3 s 14*

62P.25 REIMBURSEMENT FOR SMALL RURAL HOSPITALS.

All-payer insurers shall pay small rural hospitals on the basis of reasonable charges, subject to a rate of increase control. For purposes of this requirement, a "small rural hospital" means a hospital with 40 or fewer licensed beds that is located at least 25 miles from another facility licensed under sections 144.50 to 144.58 and operating as an acute care community hospital. The commissioner shall recommend to the legislature and the governor a methodology for determining reasonable charges as part of the implementation report due January 1, 1995.

History: *1994 c 625 art 3 s 15*

62P.27 PAYMENT FOR OUTPATIENT SERVICES.

Outpatient services provided in acute-care general hospitals and freestanding ambulatory surgery centers shall be paid on the basis of approved charges, subject to rate of increase controls. The rate of increase allowed must be consistent with the volume performance standard for physician and outpatient services.

History: *1994 c 625 art 3 s 16*

62P.29 OTHER INSTITUTIONAL PROVIDERS.

Subdivision 1. **Specialty hospitals and hospital units.** The commissioner shall develop payment mechanisms for specialty hospitals providing pediatric and psychiatric care and distinct psychiatric and rehabilitation units in hospitals. The commissioner shall present these recommendations to the legislature and governor as part of the implementation report due January 1, 1995.

Subd. 2. **Other providers.** The commissioner shall apply rate of increase limits on charges or fees to other nonhospital institutional providers. These providers include, but are not limited to, home health agencies, substance abuse treatment centers, and nursing homes, to the extent their services are included in the all-payer option. In setting rate of increase limits for institutional providers, the commissioner shall consider outcomes, comprehensiveness of services, and the special needs and severity of illness of patients treated by individual providers.

History: *1994 c 625 art 3 s 17*

62P.31 LIMITATIONS ON ALL-PAYER OPTION.

Beginning July 1, 1997, all-payer insurers shall not employ or contract with health care providers, establish a network of exclusive or preferred providers, or negotiate provider payments that differ from the all-payer fee schedule. Preferred provider organizations may continue to provide care to their existing enrollees, without becoming licensed as an integrated service network, through December 31, 1997.

History: *1994 c 625 art 3 s 18*

62P.33 RECOMMENDATIONS FOR A USER FEE.

The commissioner of health shall present to the legislature, as part of the implementation plan due January 1, 1996, recommendations for establishing and collecting a user fee from all-payer insurers. The user fee must be set at a level that reflects the state's investment in fee schedules, standard utilization reviews, quality monitoring, and other regulatory and administrative functions provided for the regulated all-payer option. The commissioner may consult actuaries in developing recommendations for and setting the level of the user fee. The commissioner may also present recommendations to establish additional fees and assessments if the commissioner determines they are needed to assure equal levels of accountability between the integrated service network system and the regulated all-payer option in terms of public health goals, serving high-risk and special needs populations, and other obligations imposed on the integrated service network system.

History: *1994 c 625 art 3 s 19*