State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 3809

March 4, 2008
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The bill was read for the first time and referred to the Committee on Health and Human Services
March 11, 2008
By motion, recalled and re-referred to the Committee on Finance

A bill for an act

relating to human services; improving management of state health care programs; modifying managed care contracting; limiting managed care administrative expenses; modifying county-based purchasing; requiring mandated 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 subdivisions; 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, subdivision 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 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, section 256B.69, is amended by adding a subdivision to read:

Subd. 5i. **Administrative expenses.** (a) Managed care plan administrative costs must not exceed, by more than five percent, the estimated administrative spending used to set the capitation rate. The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the estimated 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) Capitated rate payments for administrative costs must be reduced to exclude onetime or sporadic expenditures in the prior year unless the managed care plan certifies that the expenditure will recur during the contract year. The commissioner shall verify these certifications on an annual basis and recoup any payments made for onetime or sporadic expenditures that did not occur in the prior year.

(c) Expenses listed under section 62D.12, subdivision 9a, are not allowable administrative expenses under this section.

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.** Each managed care plan must provide to the commissioner detailed information on administrative spending, including:

(1) itemized lists of costs for claims processing and provider network management;

(2) detailed reports of costs for contracts with providers and third-party administrators;

(3) a detailed analysis of administrative spending for each Minnesota health care program;

(4) a detailed analysis of the provider's allocation of administrative expenses among its public and commercial lines of business;

(5) a detailed analysis of administrative costs by service category; and

(6) a detailed analysis of onetime and sporadic expenditures included in the administrative spending category.

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

Subd. 9b. **Reporting of subcontracts and provider payment rates.** (a) Each managed care plan must provide to the commissioner:

(1) detailed information on contracts with health care providers; and

(2) detailed information on reimbursement rates paid by the managed care plan to providers under contract with the plan.

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

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 as of January 1, 2008, the plan must have in reserve:

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

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

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

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

(2) for a county-based purchasing plan first approved after January 1, 2008, the plan must have in reserve:

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

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

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

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

(c) A county 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.

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

Subd. 4a. **Expenditure of excess revenues.** 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 for capital reserves or to repay county investments or contributions to the county-based purchasing plan, for health care programs, services, or activities.

Sec. 9. Minnesota Statutes 2006, section 256B.692, is amended by adding a subdivision to read:

Subd. 6a. **Unreasonable expenses.** No county-based purchasing plan shall incur or pay for any expense of any nature that is unreasonably high in relation to the value of the service or goods provided. The commissioner shall implement and enforce this section by rules adopted under this section.

Sec. 10. 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.

(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. 11. 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. **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 until January 1, 2009, 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.

For contract years beginning on or after January 1, 2009, single health plan arrangements with county-based purchasing plans are subject to the provisions of Minnesota Statutes, section 256B.692.

(b) For contract years beginning on or after January 1, 2009, the commissioner shall consider, and may approve, contracting on a single-health plan basis with 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.~~

Sec. 12. **REPORT ON FINANCIAL MANAGEMENT OF HEALTH CARE PROGRAMS.**

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. 13. **HEALTH PLAN REQUIREMENTS.**

(a) 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 have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs.

(b) The commissioner of health, in cooperation with the commissioner of commerce, shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, detailed standards and procedures for examining the reasonableness of health plan administrative expenditures for publicly funded programs. These standards and procedures must include a process for detailed examinations of individual programs and functional areas.

(c) The commissioner of health shall develop and report to the legislature under Minnesota Statutes, section 3.195, by January 15, 2009, a more efficient method for a health plan to demonstrate to the commissioner that providers in the plan's network have appropriate credentials. The commissioner shall review issues regarding:

(1) the duplicate review of credentials at a health care provider by multiple health plans;

(2) the review of the credentials of all staff of a health care provider when only limited staff will be in the managed care plan network; and

(3) other duplicative credentialing issues.

Sec. 14. **OMBUDSMAN FOR MANAGED CARE STUDY.**

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 the cost of this expansion.

Sec. 15. **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.