

A bill for an act
relating to health and human services; establishing oversight for rural health
cooperative; revising requirements for county-based purchasing for state health
care programs; appropriating money; amending Minnesota Statutes 2007
Supplement, section 256B.69, subdivision 4; proposing coding for new law
in Minnesota Statutes, chapter 62R.

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

Section 1. **[62R.09] RURAL HEALTH COOPERATIVE CONTRACT
OVERSIGHT.**

Subdivision 1. **Review and approval; monitoring.** (a) The commissioner shall
establish criteria and procedures to review and authorize contracts and business or
financial arrangements under section 62R.06, subdivision 1. All contracts and business
or financial arrangements must be submitted on an application for approval to the
commissioner. The commissioner shall not deny any application unless the commissioner
determines that the proposed arrangement is likely to result in higher health care costs
or diminished access to or quality of health care than would occur in the competitive
marketplace. The cost of developing the criteria and procedures, as determined by the
commissioner and notwithstanding section 16A.1283, shall be paid by health provider
cooperatives operating under this chapter.

(b) Within 30 days after receiving an application, the commissioner may request
additional information that is necessary to complete the review required under this section.
If the commissioner does not request additional information and does not act within 60
days after receipt of an application, the application shall be deemed approved if the
commissioner does not act within 60 days of receiving the additional information.

(c) The commissioner may condition approval of a proposed arrangement on a modification of all or part of the arrangement to eliminate any restriction on competition that is not reasonably related to the goals of improving health care access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against abuses of private economic power and to ensure that the arrangement has oversight by the state.

(d) The commissioner shall monitor arrangements approved under this section to ensure that the arrangement remains in compliance with the conditions of approval. The commissioner may revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval.

Subd. 2. **Applications.** Applications for approval under this section must describe the proposed arrangement in detail. The application must include: the identities of all the parties to the arrangement; the intent of the arrangement; the expected outcome of the arrangement; and an explanation of how the arrangement will improve access or quality of care. Data on providers collected under this section are private data on individuals or nonpublic data, as defined in section 13.02.

Subd. 3. **Application fee.** When submitting an application to the commissioner, a health care cooperative shall pay a fee of \$2,000 for the commissioner's cost of reviewing and monitoring the arrangement.

Subd. 4. **Appropriation.** Money received by the commissioner under this section shall be deposited into a revolving fund and is appropriated to the commissioner of health for the purpose of administering this section.

Sec. 2. Minnesota Statutes 2007 Supplement, section 256B.69, subdivision 4, is amended to read:

Subd. 4. **Limitation of choice.** (a) The commissioner shall develop criteria to determine when limitation of choice may be implemented in the experimental counties. The criteria shall ensure that all eligible individuals in the county have continuing access to the full range of medical assistance services as specified in subdivision 6.

(b) The commissioner shall exempt the following persons from participation in the project, in addition to those who do not meet the criteria for limitation of choice:

(1) persons eligible for medical assistance according to section 256B.055, subdivision 1;

(2) persons eligible for medical assistance due to blindness or disability as determined by the Social Security Administration or the state medical review team, unless:

(i) they are 65 years of age or older; or

(ii) they reside in Itasca County or they reside in a county in which the commissioner conducts a pilot project under a waiver granted pursuant to section 1115 of the Social Security Act;

(3) recipients who currently have private coverage through a health maintenance organization;

(4) recipients who are eligible for medical assistance by spending down excess income for medical expenses other than the nursing facility per diem expense;

(5) recipients who receive benefits under the Refugee Assistance Program, established under United States Code, title 8, section 1522(e);

(6) children who are both determined to be severely emotionally disturbed and receiving case management services according to section 256B.0625, subdivision 20, except children who are eligible for and who decline enrollment in an approved preferred integrated network under section 245.4682;

(7) adults who are both determined to be seriously and persistently mentally ill and received case management services according to section 256B.0625, subdivision 20;

(8) persons eligible for medical assistance according to section 256B.057, subdivision 10; and

(9) persons with access to cost-effective employer-sponsored private health insurance or persons enrolled in a non-Medicare individual health plan determined to be cost-effective according to section 256B.0625, subdivision 15.

Children under age 21 who are in foster placement may enroll in the project on an elective basis. Individuals excluded under clauses (1), (6), and (7) may choose to enroll on an elective basis. The commissioner may enroll recipients in the prepaid medical assistance program for seniors who are (1) age 65 and over, and (2) eligible for medical assistance by spending down excess income.

(c) The commissioner may allow persons with a one-month spenddown who are otherwise eligible to enroll to voluntarily enroll or remain enrolled, if they elect to prepay their monthly spenddown to the state.

(d) The commissioner may require those individuals to enroll in the prepaid medical assistance program who otherwise would have been excluded under paragraph (b), clauses (1), (3), and (8), and under Minnesota Rules, part 9500.1452, subpart 2, items H, K, and L.

(e) Before limitation of choice is implemented, eligible individuals shall be notified and after notification, shall be allowed to choose only among demonstration providers.

The commissioner may assign an individual with private coverage through a health maintenance organization, to the same health maintenance organization for medical assistance coverage, if the health maintenance organization is under contract for medical

assistance in the individual's county of residence. After initially choosing a provider, the recipient is allowed to change that choice only at specified times as allowed by the commissioner. If a demonstration provider ends participation in the project for any reason, a recipient enrolled with that provider must select a new provider but may change providers without cause once more within the first 60 days after enrollment with the second provider.

(f) An infant born to a woman who is eligible for and receiving medical assistance and who is enrolled in the prepaid medical assistance program shall be retroactively enrolled to the month of birth in the same managed care plan as the mother once the child is enrolled in medical assistance unless the child is determined to be excluded from enrollment in a prepaid plan under this section.

(g) For an eligible individual under the age of 65, in the absence of a specific managed care plan choice by the individual, the commissioner shall assign the individual to the county-based purchasing health plan in Olmsted, Winona, Houston, Fillmore, and Mower Counties, if the individual resides in one of these counties. For an eligible individual over the age of 65, the commissioner shall make this default assignment upon the county-based purchasing plan entering into a contract with the commissioner to serve this population and receiving federal approval as a special needs plan. This paragraph expires December 31, 2011, or at the conclusion of the commissioner's next scheduled repurchase process for the county-based purchasing entities covered by this paragraph, whichever occurs first.

Sec. 3. STATEMENT OF COSTS; APPROPRIATION.

By June 1, 2009, the commissioner of human services shall submit to Olmsted County an itemized statement of costs incurred by the Department of Human Services for necessary changes to the department's computer system to implement Minnesota Statutes, section 256B.69, subdivision 4, paragraph (g), along with a bill for the amount of these costs, up to \$18,000. By June 30, 2009, Olmsted County must remit to the commissioner the amount billed. The amount received by the commissioner must be deposited in the state treasury and credited to a special account and is appropriated to the commissioner as reimbursement for the costs billed.