A bill for an act

relating to human services; modifying requirements for managed care and county-based purchasing plans; providing access to data on provider payment rates; requiring managed care and county-based plans serving state health care program enrollees to annually provide data necessary to conduct cost-effectiveness audits; requiring the commissioner of human services to enter into an interagency agreement with the commissioner of commerce to conduct a cost-effectiveness audit; reducing payments to managed care plans; establishing a loss ratio for managed care and county-based purchasing plans; establishing an additional performance withhold; establishing a work group on plan regulation and reporting; requiring a report; amending Minnesota Statutes 2010, sections 256B.69, subdivisions 5a, 5i, 6, 9, 9b, by adding subdivisions; 256L.12, subdivision 9, by adding a subdivision.

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

Section 1. 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, 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.

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

(o) Effective for services provided on or after January 1, 2012, the commissioner shall withhold ... 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 outcome-based performance targets for enrollees with complex or chronic conditions. Criteria for assessment of each performance target must be outlined in writing by the commissioner prior to the contract effective date. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The withheld funds must be returned no sooner than July of the following year if the performance targets in the contract are achieved.

Sec. 2. 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) Managed care and county-based purchasing plans seeking to include an increase in administrative costs in their base payment rate must submit information on the allocation of administrative costs by category and subcategory and reasons for the increase in administrative costs, in the form and manner specified by the commissioner.

(d) A managed care or county-based purchasing plan must meet a loss ratio of no less than 92.5 percent for each program it participates in under this section, calculated as specified in this paragraph. The loss ratio consists of a numerator consisting only of direct expenses of providing patient care to persons covered under each program, excluding administrative expenses. The denominator consists of the total amount paid by the commissioner to the plan, after subtraction of taxes and other mandatory government assessments directly attributable to the plan's participation as a provider in the program being reported on. Payments by the plan to unaffiliated third parties or to providers or other entities that own, are owned by, or under common control with the plan must be divided into patient care expenses and administrative expenses and included in the appropriate category for determination of the loss ratio.

Sec. 3. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 5l. **Payment rate reduction.** In addition to the reductions in subdivisions 5g and 5h, the total payment to managed care plans under the medical assistance program is reduced by 15 percent for services provided on or after January 1, 2012. This provision excludes payments for nursing home services, home and community-based waivers, and mental health services added as covered benefits after December 31, 2007. Managed care plans are prohibited from reducing provider payment rates to reflect this reduction, and the commissioner shall ensure that the provider payment rates in effect for the contract year beginning January 1, 2012, are not lower than the provider payment rates in effect for the contract year beginning January 1, 2011.

Sec. 4. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) ~~may~~ shall seek to contract with federally qualified health centers and other health care and social service practitioners to provide coordinated health care and social services to enrollees from high-risk or medically underserved populations; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

Sec. 5. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as required by the commissioner, including data required for assessing client satisfaction, quality of care, cost, and utilization of services for purposes of project evaluation. The commissioner shall also develop methods of data reporting and collection in order to provide aggregate enrollee information on encounters and outcomes to determine access and quality assurance. Required information shall be specified before the commissioner contracts with a demonstration provider.

(b) Aggregate nonpersonally identifiable health plan encounter data, aggregate spending data for major categories of service as reported to the commissioners of health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for service authorization and service use are public data that the commissioner shall make available and use in public reports. The commissioner shall require each health plan and county-based purchasing plan to provide:

(1) encounter data for each service provided, using standard codes and unit of service definitions set by the commissioner, in a form that the commissioner can report by age, eligibility groups, and health plan; and

(2) criteria, written policies, and procedures required to be disclosed under section 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used for each type of service for which authorization is required.

(c) The commissioner shall require managed care and county-based purchasing plans to report financial data separately by public and private lines of business.

(d) The commissioner shall contract with an actuary to collect the financial, utilization, quality, and other data that managed care and county-based purchasing plans are required to submit under this section. The commissioner, in consultation with the actuary under contract, shall set uniform criteria, definitions, and standards for the data to be submitted, and shall require managed care and county-based purchasing plans to comply with these criteria, definitions, and standards when submitting data to the actuary under contract.

Sec. 6. Minnesota Statutes 2010, section 256B.69, subdivision 9b, is amended to read:

Subd. 9b. **Reporting provider payment rates.** (a) According to guidelines developed by the commissioner, in consultation with health care providers, managed care plans, and county-based purchasing plans, each managed care plan and county-based purchasing plan must annually provide to the commissioner information on reimbursement rates paid by the managed care plan under this section or the county-based purchasing plan under section 256B.692 to providers and vendors for administrative services under contract with the plan.

(b) Each managed care plan and county-based purchasing plan must annually provide to the commissioner, in the form and manner specified by the commissioner:

(1) the amount of the payment made to the plan under this section that is paid to health care providers for patient care;

(2) aggregate provider payment data, categorized by inpatient payments and outpatient payments, with the outpatient payments categorized by payments to primary care providers and nonprimary care providers;

(3) the process by which increases or decreases in payments made to the plan under this section, that are based on actuarial analysis related to provider cost increases or decreases, or that are required by legislative action, are passed through to health care providers, categorized by payments to primary care providers and nonprimary care providers; and

(4) specific information on the methodology used to establish provider reimbursement rates paid by the managed health care plan and county-based purchasing plan.

Data provided to the commissioner under this subdivision must allow the commissioner to conduct the analyses required under paragraph (d).

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

(d) The commissioner shall analyze data provided under this subdivision to assist the legislature in providing oversight and accountability related to expenditures under this section. The analysis must include information on payments to physicians, physician extenders, and hospitals, and may include other provider types as determined by the commissioner. The commissioner shall also array aggregate provider reimbursement rates by health plan, by primary care, and by nonprimary care categories. The commissioner shall report the analysis to the legislature annually, beginning December 15, 2010, and each December 15 thereafter. The commissioner shall also make this information available on the agency's Web site to managed care and county-based purchasing plans, health care providers, and the public.

Sec. 7. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision to read:

Subd. 9c. **Cost-effectiveness audit.** (a) The commissioner shall require each managed care and county-based purchasing plan, as a condition of contract, to annually provide to the commissioner, in the form and manner specified by the commissioner, data necessary for the commissioner or another entity to conduct an audit to determine if the managed care or county-based purchasing plan provides covered services to medical assistance and MinnesotaCare program enrollees in a cost-effective and efficient manner, relative to the capitation payments received and the performance of health plan companies serving private sector enrollees. Plans shall submit to the commissioner, by July 1 of each year, data for the preceding contract year.

(b) The data collected must include, but is not limited to:

(1) expenditures by category, including claims and administrative costs by subcategory;

(2) revenues by category, including capitation payments by enrollee category, return on investment, and revenues from cost-sharing;

(3) provider payments by provider type;

(4) per-enrollee expenditures and utilization by age, gender, region, and eligibility basis of the enrollee;

(5) net returns for public and private sector products and contributions to reserves;

(6) quality of care measures, including information on the achievement of performance targets; and

(7) other data the commissioner determines is necessary to complete a cost-effectiveness audit.

(c) Data provided to the commissioner under this subdivision are public data as defined under section 13.02.

(d) The commissioner shall enter into an interagency agreement with the commissioner of commerce to conduct a cost-effectiveness audit of each managed care and county-based purchasing plan, using the data submitted by each plan under paragraph (b). The audit must evaluate the extent to which managed care and county-based purchasing plans provide covered services to medical assistance and MinnesotaCare program enrollees in a cost-effective and efficient manner, relative to capitation payments received and the performance of health plan companies providing coverage to private sector enrollees. In conducting the audit, the commissioner shall consider differences between public and private sector coverage, including but not limited to differences in benefit sets, enrollee characteristics, and the use of underwriting. The commissioner of commerce shall present audit findings to the commissioner of human services and the legislature by November 1, 2011, and shall include with these findings recommendations for any changes in capitation rates or other legislative or administrative changes necessary to improve cost-effectiveness and efficiency of individual managed care and county-based purchasing plans, and the prepaid medical assistance and prepaid MinnesotaCare programs.

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

Sec. 8. 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, 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.

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 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) 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.

(f) Effective for services provided on or after January 1, 2012, the commissioner shall withhold ... percent of managed care plan and county-based purchasing plan payments for the prepaid MinnesotaCare program pending completion of outcome-based performance targets for enrollees with complex or chronic conditions. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The withheld funds must be returned no sooner than July of the following year if the performance targets in the contract are achieved.

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

Subd. 9c. **Rate reduction.** In addition to the reductions in subdivisions 9a and 9b, the total payment to managed care plans under the MinnesotaCare program is reduced by 15 percent for services provided on or after January 1, 2012. This provision excludes payments for mental health services added as covered benefits after December 31, 2007. Managed care plans are prohibited from reducing provider payment rates to reflect this reduction, and the commissioner shall ensure that the provider payment rates in effect for the contract year beginning January 1, 2012, are not lower than the provider payment rates in effect for the contract year beginning January 1, 2011.

Sec. 10. **WORK GROUP ON PLAN REGULATION AND REPORTING.**

The commissioner of human services shall convene a work group to study and make recommendations on managed care plan and county-based purchasing plan regulatory and reporting requirements under Minnesota Statutes, section 256B.69. The work group shall consist of representatives of managed care and county-based purchasing plans, consumers, and health care providers. The work group shall also include two members of the Minnesota house of representatives appointed by the speaker of the house and two members of the Minnesota senate appointed by the Subcommittee on Committees of the senate Committee on Rules and Administration, with no more than one member of each body being from the majority party. The work group shall recommend to the legislature and the commissioner of human services, by January 15, 2012, any changes in plan regulatory and reporting requirements necessary to:

(1) provide state agencies and the legislature with the information necessary to monitor plan performance and efficiency;

(2) allow state agencies and the legislature to ensure that capitation rates and plan administrative costs are reasonable and consistent with efficient management by the plan;

(3) avoid unnecessary duplication in reporting; and

(4) reduce plan administrative expenses.