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03/12/2018	6428	Introduction and first reading Referred to Health and Human Services Finance and Policy
03/15/2018	6531	Author added Lourey

A bill for an act

relating to health care; creating a separate chapter for county-based purchasing plans operating under Minnesota Statutes, section 256B.692; amending Minnesota Statutes 2016, sections 62A.045; 62M.06, subdivision 1; 62Q.80, subdivision 2; 62U.01, subdivision 8; 125A.023, subdivision 3; 245.4682, subdivision 3; 246.50, subdivision 11; 253B.045, subdivision 5; 256.015, subdivision 1; 256B.042, subdivision 1; 256B.056, subdivision 6; 256B.0625, subdivision 9; 256B.0631, subdivision 1; 256B.37, subdivision 2; 256B.69, subdivisions 2, 3a, 5a, 5i, 6b, 9a, 9c, 9d, 26; 256B.694; 256B.756, subdivision 3; 256B.77, subdivision 3; 256L.01, subdivision 7; 256L.12, subdivision 9; 256L.121, subdivision 3; Minnesota Statutes 2017 Supplement, sections 3.972, subdivision 2b; 256B.6925, subdivision 4; 256B.76, subdivisions 1, 2; 256B.761; proposing coding for new law as Minnesota Statutes, chapter 62W; repealing Minnesota Statutes 2016, section 256B.692, subdivisions 1, 2, 3, 4, 4a, 5, 7, 8, 9; Minnesota Statutes 2017 Supplement, section 256B.692, subdivision 6.

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

ARTICLE 1

COUNTY-BASED PURCHASING

Section 1. **[62W.01] CITATION AND PURPOSE.**

Subdivision 1. **Citation.** This chapter may be cited as "county-based purchasing."

Subd. 2. **Purpose.** County-based purchasing is a model uniquely designed to serve rural areas by providing health care services, behavioral health services, public health services, social services, and other community-based services through local coordination, collaboration, and integration. County-based purchasing is an effective model to provide:

(1) local accountability and transparency in health care financing within a budget;

(2) long-term continuity in delivering and receiving health care coverage through federal and state public health care programs;

(3) local innovation in the design, practice, and evaluation of new health care initiatives to specifically address unique local health care needs involving access, quality, efficiency, and service delivery while providing value-based accountable care consistent with state and federal health care reform objectives; and

(4) development and maintenance of rural health care infrastructure.

Sec. 2. **[62W.02] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the following terms have the meanings given them.

Subd. 2. **Commissioner.** "Commissioner" means the commissioner of health or the commissioner's designee.

Subd. 3. **County-based purchasing organization.** "County-based purchasing organization" means a rural county or group of rural counties that has elected to operate a county-based purchasing plan in accordance with this chapter. If only one county is involved, the county board of commissioners shall be the governing body of the county-based purchasing organization. If a multicounty arrangement is involved, the governing body of the county-based purchasing organization shall be a joint powers board established under section 471.59.

Subd. 4. **County-based purchasing plan.** "County-based purchasing plan" means a plan offered by the county-based purchasing organization whereby the organization agrees to purchase or provide health care services, behavioral health services, public health services, county social services, community support services, and other community-based services and resources to address the wellness, health care, and social needs of enrollees as set forth under the plan and in accordance with this chapter.

Subd. 5. **Enrollee.** "Enrollee" means an individual who resides within the service area served by the county-based purchasing organization and who is enrolled in the county-based purchasing plan.

Subd. 6. **Rural.** "Rural" means any county designated as micro, rural, or a county with extreme access considerations (CEAC) under the Medicare Advantage health care delivery reference table for the most recent reporting period.

Subd. 7. **Service area.** "Service area" means the geographic area served by the county-based purchasing organization.

Sec. 3. **[62W.03] COUNTY-BASED PURCHASING ORGANIZATIONS.**

Subdivision 1. **Certificate of authority.** A county board or group of county boards must apply to the commissioner of health for a certificate of authority to operate a county-based purchasing organization in compliance with this chapter.

Subd. 2. **Local planning process.** A county board or joint powers board that intends to submit an application under this section must establish a local planning process to advise the county or counties on the development of the application and its proposed implementation. The planning process must include input from potential enrollees, consumer advocates, local providers, and representatives of the local school district, labor force, and tribal governments.

Subd. 3. **Application review.** (a) Upon receipt of an application for a certificate of authority, the commissioner shall determine whether the applicant for the certificate of authority has substantially demonstrated the applicant's ability to meet the requirements of this chapter.

(b) In reviewing the application, approval shall not be unreasonably withheld and the commissioner shall take into account the purpose and functions of county-based purchasing organizations as stated in this chapter. The commissioner may consult with the commissioner of human services if the county-based purchasing organization intends to provide or purchase health care services under medical assistance or MinnesotaCare.

Subd. 4. **Certificate of authority requirements.** (a) Before issuing a certificate of authority, the county-based purchasing organization must demonstrate to the commissioner the ability to follow and agree to:

(1) authorize and arrange for the provision of all needed health services to ensure all appropriate health care is delivered to enrollees;

(2) ensure that all covered health services are accessible to all enrollees and that enrollees have a reasonable choice of providers to the extent possible. If the county is also a health care provider, the county-based purchasing organization must develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers that meet the same quality and cost requirements are available;

(3) meet the fiscal solvency requirements schedule in subdivision 5;

(4) comply with the provisions in sections 62J.48, 62J.71 to 62J.73, 62M.01 to 62M.16, and 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, and 62Q.68 to 62Q.72;

(5) issue payments to participating providers or vendors in a timely manner and comply with the standards for claim settlement under section 72A.201, subdivisions 4, 5, 7, and 8;

(6) establish consumer protection and provider protection requirements that are applicable to health maintenance organizations under chapter 62D;

(7) provide a system for advocacy, enrollee grievance procedures, and complaints and appeals that is independent of providers or other risk bearers; and

(8) provide appropriate quality and other required data in a format required by the commissioner.

(b) The commissioner, in consultation with the county board or joint powers board, shall develop administrative and financial reporting requirements for the county-based purchasing organization relating to sections 62D.041, 62D.042, 62D.045, 62D.08, 62N.29, and 62N.31 and other sections that are specific to county administrative, accounting, and reporting systems and that are consistent with other statutory requirements for counties.

Subd. 5. **Fiscal solvency.** (a) A county-based purchasing organization must have on reserve:

(1) at least 50 percent of the minimum amount required under chapter 62D at the time the organization begins operation;

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

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

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

(b) Until the county-based purchasing organization is required to have reserves that equal at least 100 percent of the minimum amount required under chapter 62D, the organization may demonstrate its ability to cover any losses by satisfying the requirements of chapter 62N.

Subd. 6. **Issuance; notice.** (a) Within 90 days after the receipt of the application for certificate of authority, the commissioner of health shall determine whether or not the application meets the requirements of this chapter. If the commissioner determines that the

applicant meets the requirements of this chapter, the commissioner shall issue a certificate of authority. If the commissioner determines that the applicant is not qualified, the commissioner shall notify the applicant and shall specify the reason or reasons for the disqualification.

(b) In the event the commissioner rejects an application under this chapter, the county board, the joint powers board, or a single entity representing the county board or joint powers board may request a review by a three-person mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner, and one person selected jointly by the designee of the commissioner and the designee of the Association of Minnesota Counties. The commissioner shall make a final determination on the application after considering the recommendation of the three-person mediation panel.

Subd. 7. **Enforcement; rulemaking.** All enforcement and rulemaking powers available to the commissioner of health under chapters 62D, 62J, 62M, 62N, and 62Q are granted to the commissioner with respect to counties that operate a county-based purchasing organization.

Subd. 8. **Continued compliance.** (a) Upon being granted a certificate of authority to operate as a county-based purchasing organization, the organization must continue to comply with the standards in this chapter. Noncompliance may result in the suspension or revocation of the certificate of authority.

(b) The county-based purchasing organization shall conduct its operations in a publicly transparent and accountable manner, and in compliance with all regulations applicable to government entities, including providing enrollees and participating providers opportunities to be involved in the governance of the county-based purchasing organization.

Subd. 9. **Hold harmless.** A county-based purchasing organization operating a county-based purchasing plan must ensure that the state and enrollees are held harmless for any payment obligations incurred by the county-based purchasing plan if the county-based purchasing organization becomes insolvent and the state has made capitation payments to the county-based purchasing organization under section 256B.69 or 256L.12.

Sec. 4. **[62W.04] FEES.**

(a) The commissioner of health shall collect from each county-based purchasing organization the following fees:

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

(2) an annual fee of $21,500 to be paid by June 15 of each calendar year.

(b) All fees collected under this section shall be deposited in the state government special revenue fund.

Sec. 5. **[62W.05] EXISTING COUNTY-BASED PURCHASING ORGANIZATIONS.**

(a) A county-based purchasing plan that was established under section 256B.692 and is operating on January 1, 2018, is deemed to have met the requirements of this chapter and is not required to submit a new application to the commissioner. The commissioner shall issue a certificate of authority to these county-based purchasing organizations.

(b) Nothing in paragraph (a) shall be construed to exempt a county-based purchasing organization from the other provisions of this chapter or section 256B.69.

Sec. 6. **[62W.06] EXPENDITURE OF REVENUES.**

(a) A county-based purchasing organization operating a county-based purchasing plan must use any excess revenues over expenses that are received by the county-based purchasing organization:

(1) for capital reserves under section 62W.03, subdivision 5;

(2) to increase payments to providers;

(3) for early intervention and public health services and activities; or

(4) to improve economic and geographic access to and the delivery of cost-effective quality health care.

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

Sec. 7. **[62W.07] PARTICIPATION IN GOVERNMENT PROGRAMS.**

Subdivision 1. **County proposals.** A county-based purchasing organization may, upon obtaining a certificate of authority under this chapter, offer a county-based purchasing plan for the purpose of providing health care services on behalf of eligible individuals in accordance with sections 256B.69 and 256L.12. The county-based purchasing organization may purchase all or part of services from a third-party administrator or individual providers

on a fee-for-service basis, or provide these services directly. The county-based purchasing plan may participate in any contract procurement process under section 256B.69 that includes the counties within the county-based purchasing plan's service area in accordance with state and federal procurement laws.

Subd. 2. **Notice.** If a county-based purchasing organization elects to offer a county-based purchasing plan in a county or group of counties where a county-based purchasing plan has not been implemented and plans to participate in the procurement process under section 256B.69, the county-based purchasing organization must provide notice to the commissioner of human services at least 15 months prior to the termination date of the existing managed care plan contract that covers eligible individuals in that county or group of counties.

Subd. 3. **Transfer of risk.** If the county-based purchasing plan contracts with the commissioner of human services under section 256B.69 or 256L.12, the state of Minnesota and the United States Department of Health and Human Services are not liable for any costs incurred by a county or a county-based purchasing plan that exceed the payments to the county-based purchasing organization made under this section or section 256B.69 or 256L.12. A county or group of counties whose costs exceed the payments made by the state, an enrollee of the county-based purchasing plan, or a creditor of that county shall have no rights under chapter 61B or section 62D.181. A county may assign risk for the cost of care to a third party.

Sec. 8. Minnesota Statutes 2016, section 256B.69, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Commissioner" means the commissioner of human services. For the remainder of this section, the commissioner's responsibilities for methods and policies for implementing the project will be proposed by the project advisory committees and approved by the commissioner.

(b) "Demonstration provider" means a health maintenance organization, community integrated service network, ~~or~~ accountable provider network, or county-based purchasing organization authorized and operating under chapter 62D, 62N, ~~or~~ 62T, or 62W that participates in the demonstration project according to criteria, standards, methods, and other requirements established for the project and approved by the commissioner. ~~For purposes of this section, a county board, or group of county boards operating under a joint powers agreement, is considered a demonstration provider if the county or group of county boards meets the requirements of section 256B.692.~~

(c) "Eligible individuals" means those persons eligible for medical assistance benefits as defined in sections 256B.055, 256B.056, and 256B.06.

(d) "Limitation of choice" means suspending freedom of choice while allowing eligible individuals to choose among the demonstration providers.

Sec. 9. Minnesota Statutes 2016, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of ~~initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of~~ procurement or contract renewal that involves that county or group of counties. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of

health plan functions and within the scope of the medical assistance benefit set. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical assistance program in that county ~~at initial implementation of the program in that county and~~ at the time of a procurement process or contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

~~(c) For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.~~

~~(d)~~ (c) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

~~(e) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based purchasing for a period of five years from the date it discontinues purchasing.~~

~~(f) The commissioner shall not require that contractual disputes between county-based purchasing entities and the commissioner be mediated by a panel that includes a representative of the Minnesota Council of Health Plans.~~

~~(g)~~ (d) At the request of a county-purchasing entity, the commissioner shall adopt a contract reprocurement or renewal schedule under which all counties included in the entity's service area are reprocured or renewed at the same time.

~~(h)~~ (e) The commissioner shall provide a written report under section 3.195 to the chairs of the legislative committees having jurisdiction over human services in the senate and the house of representatives describing in detail the activities undertaken by the commissioner to ensure full compliance with this section. The report must also provide an explanation for any decisions of the commissioner not to accept the recommendations of a county or group of counties required to be consulted under this section. The report must be provided at least 30 days prior to the effective date of a new or renewed prepaid or managed care contract in a county.

Sec. 10. **REPEALER.**

(a) Minnesota Statutes 2016, sections 256B.692, subdivisions 1, 2, 3, 4, 4a, 5, 7, 8, and 9, are repealed.

(b) Minnesota Statutes 2017 Supplement, section 256B.692, subdivision 6, is repealed.

ARTICLE 2

CONFORMING CHANGES

Section 1. Minnesota Statutes 2017 Supplement, section 3.972, subdivision 2b, is amended to read:

Subd. 2b. **Audits of managed care organizations.** (a) The legislative auditor shall audit each managed care organization that contracts with the commissioner of human services to provide health care services under sections 256B.69~~, 256B.692,~~ and 256L.12. The legislative auditor shall design the audits to determine if a managed care organization used the public money in compliance with federal and state laws, rules, and in accordance with provisions in the managed care organization's contract with the commissioner of human services. The legislative auditor shall determine the schedule and scope of the audit work and may contract with vendors to assist with the audits. The managed care organization must cooperate with the legislative auditor and must provide the legislative auditor with all data, documents, and other information, regardless of classification, that the legislative auditor requests to conduct an audit. The legislative auditor shall periodically report audit results and recommendations to the Legislative Audit Commission and the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance.

(b) For purposes of this subdivision, a "managed care organization" means a demonstration provider as defined under section 256B.69, subdivision 2.

Sec. 2. Minnesota Statutes 2016, section 62A.045, is amended to read:

62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT HEALTH PROGRAMS.

(a) As a condition of doing business in Minnesota or providing coverage to residents of Minnesota covered by this section, each health insurer shall comply with the requirements of the federal Deficit Reduction Act of 2005, Public Law 109-171, including any federal regulations adopted under that act, to the extent that it imposes a requirement that applies in this state and that is not also required by the laws of this state. This section does not require compliance with any provision of the federal act prior to the effective date provided for that provision in the federal act. The commissioner shall enforce this section.

For the purpose of this section, "health insurer" includes self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are by contract legally responsible to pay a claim for a health-care item or service for an individual receiving benefits under paragraph (b).

(b) No plan offered by a health insurer issued or renewed to provide coverage to a Minnesota resident shall contain any provision denying or reducing benefits because services are rendered to a person who is eligible for or receiving medical benefits pursuant to title XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B; or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2; 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits under plans covered by this section shall use eligibility for medical programs named in this section as an underwriting guideline or reason for nonacceptance of the risk.

(c) If payment for covered expenses has been made under state medical programs for health care items or services provided to an individual, and a third party has a legal liability to make payments, the rights of payment and appeal of an adverse coverage decision for the individual, or in the case of a child their responsible relative or caretaker, will be subrogated to the state agency. The state agency may assert its rights under this section within three years of the date the service was rendered. For purposes of this section, "state agency" includes prepaid health plans under contract with the commissioner according to sections 256B.69 and 256L.12; children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; and nursing

homes under the alternative payment demonstration project under section 256B.434~~; and county-based purchasing entities under section 256B.692~~.

(d) Notwithstanding any law to the contrary, when a person covered by a plan offered by a health insurer receives medical benefits according to any statute listed in this section, payment for covered services or notice of denial for services billed by the provider must be issued directly to the provider. If a person was receiving medical benefits through the Department of Human Services at the time a service was provided, the provider must indicate this benefit coverage on any claim forms submitted by the provider to the health insurer for those services. If the commissioner of human services notifies the health insurer that the commissioner has made payments to the provider, payment for benefits or notices of denials issued by the health insurer must be issued directly to the commissioner. Submission by the department to the health insurer of the claim on a Department of Human Services claim form is proper notice and shall be considered proof of payment of the claim to the provider and supersedes any contract requirements of the health insurer relating to the form of submission. Liability to the insured for coverage is satisfied to the extent that payments for those benefits are made by the health insurer to the provider or the commissioner as required by this section.

(e) When a state agency has acquired the rights of an individual eligible for medical programs named in this section and has health benefits coverage through a health insurer, the health insurer shall not impose requirements that are different from requirements applicable to an agent or assignee of any other individual covered.

(f) A health insurer must process a clean claim made by a state agency for covered expenses paid under state medical programs within 90 business days of the claim's submission. A health insurer must process all other claims made by a state agency for covered expenses paid under a state medical program within the timeline set forth in Code of Federal Regulations, title 42, section 447.45(d)(4).

(g) A health insurer may request a refund of a claim paid in error to the Department of Human Services within two years of the date the payment was made to the department. A request for a refund shall not be honored by the department if the health insurer makes the request after the time period has lapsed.

Sec. 3. Minnesota Statutes 2016, section 62M.06, subdivision 1, is amended to read:

Subdivision 1. **Procedures for appeal.** (a) A utilization review organization must have written procedures for appeals of determinations not to certify. The right to appeal must be available to the enrollee and to the attending health care professional.

(b) The enrollee shall be allowed to review the information relied upon in the course of the appeal, present evidence and testimony as part of the appeals process, and receive continued coverage pending the outcome of the appeals process. This paragraph does not apply to managed care plans or county-based purchasing plans serving state public health care program enrollees under section 256B.69~~, 256B.692,~~ or chapter 256L, or to grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this paragraph shall be construed to limit or restrict the appeal rights of state public health care program enrollees provided under section 256.045 and Code of Federal Regulations, title 42, section 438.420(d).

Sec. 4. Minnesota Statutes 2016, section 62Q.80, subdivision 2, is amended to read:

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Community-based" means located in or primarily relating to the community, as determined by the board of a community-based health initiative that is served by the community-based health care coverage program.

(b) "Community-based health care coverage program" or "program" means a program administered by a community-based health initiative that provides health care services through provider members of a community-based health network or combination of networks to eligible individuals and their dependents who are enrolled in the program.

(c) "Community-based health initiative" or "initiative" means a nonprofit corporation that is governed by a board that has at least 80 percent of its members residing in the community and includes representatives of the participating network providers and employers, or a county-based purchasing organization ~~as defined in section 256B.692~~ operating under chapter 62W.

(d) "Community-based health network" means a contract-based network of health care providers organized by the community-based health initiative to provide or support the delivery of health care services to enrollees of the community-based health care coverage program on a risk-sharing or nonrisk-sharing basis.

(e) "Dependent" means an eligible employee's spouse or child who is under the age of 26 years.

Sec. 5. Minnesota Statutes 2016, section 62U.01, subdivision 8, is amended to read:

Subd. 8. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4. For the purposes of this chapter, health plan company shall

include a county-based purchasing ~~arrangements authorized under section 256B.692~~ organization operating under chapter 62W.

Sec. 6. Minnesota Statutes 2016, section 125A.023, subdivision 3, is amended to read:

Subd. 3. **Definitions.** For purposes of this section and section 125A.027, the following terms have the meanings given them:

(a) "Health plan" means:

(1) a health plan under section 62Q.01, subdivision 3;

(2) a county-based purchasing plan under ~~section 256B.692~~ chapter 62W;

(3) a self-insured health plan established by a local government under section 471.617; or

(4) self-insured health coverage provided by the state to its employees or retirees.

(b) For purposes of this section, "health plan company" means an entity that issues a health plan as defined in paragraph (a).

(c) "Interagency intervention service system" means a system that coordinates services and programs required in state and federal law to meet the needs of eligible children with disabilities ages three through 21, including:

(1) services provided under the following programs or initiatives administered by state or local agencies:

(i) the maternal and child health program under title V of the Social Security Act;

(ii) the Minnesota children with special health needs program under sections 144.05 and 144.07;

(iii) the Individuals with Disabilities Education Act, Part B, section 619, and Part C as amended;

(iv) medical assistance under title 42, chapter 7, of the Social Security Act;

(v) developmental disabilities services under chapter 256B;

(vi) the Head Start Act under title 42, chapter 105, of the Social Security Act;

(vii) vocational rehabilitation services provided under chapters 248 and 268A and the Rehabilitation Act of 1973;

(viii) Juvenile Court Act services provided under sections 260.011 to 260.91; 260B.001 to 260B.446; and 260C.001 to 260C.451;

(ix) Minnesota Comprehensive Children's Mental Health Act under section 245.487;

(x) the community health services grants under sections 145.88 to 145.9266;

(xi) the Local Public Health Act under chapter 145A; and

(xii) the Vulnerable Children and Adults Act, sections 256M.60 to 256M.80;

(2) service provision and funding that can be coordinated through:

(i) the children's mental health collaborative under section 245.493;

(ii) the family services collaborative under section 124D.23;

(iii) the community transition interagency committees under section 125A.22; and

(iv) the interagency early intervention committees under section 125A.259;

(3) financial and other funding programs to be coordinated including medical assistance under title 42, chapter 7, of the Social Security Act, the MinnesotaCare program under chapter 256L, Supplemental Social Security Income, Developmental Disabilities Assistance, and any other employment-related activities associated with the Social Security Administration; and services provided under a health plan in conformity with an individual family service plan or an individualized education program or an individual interagency intervention plan; and

(4) additional appropriate services that local agencies and counties provide on an individual need basis upon determining eligibility and receiving a request from (i) the school board or county board and (ii) the child's parent.

(d) "Children with disabilities" has the meaning given in section 125A.02.

(e) A "standardized written plan" means those individual services or programs, with accompanying funding sources, available through the interagency intervention service system to an eligible child other than the services or programs described in the child's individualized education program or the child's individual family service plan.

Sec. 7. Minnesota Statutes 2016, section 245.4682, subdivision 3, is amended to read:

Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three projects to demonstrate the integration of physical and mental health services within prepaid health plans and their coordination with social services. The commissioner shall require that each project be based on locally defined partnerships that include at least one health maintenance organization, community integrated service network, or accountable provider

network authorized and operating under chapter 62D, 62N, or 62T, or county-based purchasing ~~entity~~ organization operating under ~~section 256B.692~~ chapter 62W that is eligible to contract with the commissioner as a prepaid health plan, and the county or counties within the service area. Counties shall retain responsibility and authority for social services in these locally defined partnerships.

(b) The commissioner, in consultation with consumers, families, and their representatives, shall:

(1) determine criteria for approving the projects and use those criteria to solicit proposals for preferred integrated networks. The commissioner must develop criteria to evaluate the partnership proposed by the county and prepaid health plan to coordinate access and delivery of services. The proposal must at a minimum address how the partnership will coordinate the provision of:

(i) client outreach and identification of health and social service needs paired with expedited access to appropriate resources;

(ii) activities to maintain continuity of health care coverage;

(iii) children's residential mental health treatment and treatment foster care;

(iv) court-ordered assessments and treatments;

(v) prepetition screening and commitments under chapter 253B;

(vi) assessment and treatment of children identified through mental health screening of child welfare and juvenile corrections cases;

(vii) home and community-based waiver services;

(viii) assistance with finding and maintaining employment;

(ix) housing; and

(x) transportation;

(2) determine specifications for contracts with prepaid health plans to improve the plan's ability to serve persons with mental health conditions, including specifications addressing:

(i) early identification and intervention of physical and behavioral health problems;

(ii) communication between the enrollee and the health plan;

(iii) facilitation of enrollment for persons who are also eligible for a Medicare special needs plan offered by the health plan;

(iv) risk screening procedures;

(v) health care coordination;

(vi) member services and access to applicable protections and appeal processes;

(vii) specialty provider networks;

(viii) transportation services;

(ix) treatment planning; and

(x) administrative simplification for providers;

(3) begin implementation of the projects no earlier than January 1, 2009, with not more than 40 percent of the statewide population included during calendar year 2009 and additional counties included in subsequent years;

(4) waive any administrative rule not consistent with the implementation of the projects;

(5) allow potential bidders at least 90 days to respond to the request for proposals; and

(6) conduct an independent evaluation to determine if mental health outcomes have improved in that county or counties according to measurable standards designed in consultation with the advisory body established under this subdivision and reviewed by the State Advisory Council on Mental Health.

(c) Notwithstanding any statute or administrative rule to the contrary, the commissioner may enroll all persons eligible for medical assistance with serious mental illness or emotional disturbance in the prepaid plan of their choice within the project service area unless:

(1) the individual is eligible for home and community-based services for persons with developmental disabilities and related conditions under section 256B.092; or

(2) the individual has a basis for exclusion from the prepaid plan under section 256B.69, subdivision 4, other than disability, mental illness, or emotional disturbance.

(d) The commissioner shall involve organizations representing persons with mental illness and their families in the development and distribution of information used to educate potential enrollees regarding their options for health care and mental health service delivery under this subdivision.

(e) If the person described in paragraph (c) does not elect to remain in fee-for-service medical assistance, or declines to choose a plan, the commissioner may preferentially assign that person to the prepaid plan participating in the preferred integrated network. The

commissioner shall implement the enrollment changes within a project's service area on the timeline specified in that project's approved application.

(f) A person enrolled in a prepaid health plan under paragraphs (c) and (d) may disenroll from the plan at any time.

(g) The commissioner, in consultation with consumers, families, and their representatives, shall evaluate the projects begun in 2009, and shall refine the design of the service integration projects before expanding the projects. The commissioner shall report to the chairs of the legislative committees with jurisdiction over mental health services by March 1, 2008, on plans for evaluation of preferred integrated networks established under this subdivision.

(h) The commissioner shall apply for any federal waivers necessary to implement these changes.

(i) Payment for Medicaid service providers under this subdivision for the months of May and June will be made no earlier than July 1 of the same calendar year.

Sec. 8. Minnesota Statutes 2016, section 246.50, subdivision 11, is amended to read:

Subd. 11. **Health plan company.** "Health plan company" has the meaning given ~~it~~ in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in section 256B.69, subdivision 2, paragraph (b), ~~a county or group of counties participating in county-based purchasing according to section 256B.692,~~ and a children's mental health collaborative under contract to provide medical assistance for individuals enrolled in the prepaid medical assistance and MinnesotaCare programs under sections 245.493 to 245.495.

Sec. 9. Minnesota Statutes 2016, section 253B.045, subdivision 5, is amended to read:

Subd. 5. **Health plan company; definition.** For purposes of this section, "health plan company" has the meaning given it in section 62Q.01, subdivision 4, and also includes a demonstration provider as defined in section 256B.69, subdivision 2, paragraph (b), a ~~county or group of counties participating in~~ county-based purchasing ~~according to section 256B.692~~ organization operating under chapter 62W, and a children's mental health collaborative under contract to provide medical assistance for individuals enrolled in the prepaid medical assistance and MinnesotaCare programs according to sections 245.493 to 245.495.

Sec. 10. Minnesota Statutes 2016, section 256.015, subdivision 1, is amended to read:

Subdivision 1. **State agency has lien.** When the state agency provides, pays for, or becomes liable for medical care or furnishes subsistence or other payments to a person, the

agency shall have a lien for the cost of the care and payments on any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury which accrue to the person to whom the care or payments were furnished, or to the person's legal representatives, as a result of the occurrence that necessitated the medical care, subsistence, or other payments. For purposes of this section, "state agency" includes ~~prepaid health~~ managed care plans and county-based purchasing plans under contract with the commissioner according to sections 256B.69, 256L.01, subdivision 7, 256L.03, subdivision 6, and 256L.12, and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; and nursing homes under the alternative payment demonstration project under section 256B.434~~; and county-based purchasing entities under section 256B.692~~.

Sec. 11. Minnesota Statutes 2016, section 256B.042, subdivision 1, is amended to read:

Subdivision 1. **Lien for cost of care.** When the state agency provides, pays for, or becomes liable for medical care, it shall have a lien for the cost of the care upon any and all causes of action or recovery rights under any policy, plan, or contract providing benefits for health care or injury, which accrue to the person to whom the care was furnished, or to the person's legal representatives, as a result of the illness or injuries which necessitated the medical care. For purposes of this section, "state agency" includes ~~prepaid health~~ managed care plans and county-based purchasing plans under contract with the commissioner according to sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; and nursing facilities under the alternative payment demonstration project under section 256B.434~~; and county-based purchasing entities under section 256B.692~~.

Sec. 12. Minnesota Statutes 2016, section 256B.056, subdivision 6, is amended to read:

Subd. 6. **Assignment of benefits.** To be eligible for medical assistance a person must have applied or must agree to apply all proceeds received or receivable by the person or the person's legal representative from any third party liable for the costs of medical care. By accepting or receiving assistance, the person is deemed to have assigned the person's rights to medical support and third-party payments as required by title 19 of the Social Security Act. Persons must cooperate with the state in establishing paternity and obtaining third-party payments. By accepting medical assistance, a person assigns to the Department of Human Services all rights the person may have to medical support or payments for medical expenses

from any other person or entity on their own or their dependent's behalf and agrees to cooperate with the state in establishing paternity and obtaining third-party payments. Any rights or amounts so assigned shall be applied against the cost of medical care paid for under this chapter. Any assignment takes effect upon the determination that the applicant is eligible for medical assistance and up to three months prior to the date of application if the applicant is determined eligible for and receives medical assistance benefits. The application must contain a statement explaining this assignment. For the purposes of this section, "the Department of Human Services or the state" includes ~~prepaid health~~ managed care plans and county-based purchasing plans under contract with the commissioner according to sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; and nursing facilities under the alternative payment demonstration project under section 256B.434~~; and the county-based purchasing entities under section 256B.692~~.

Sec. 13. Minnesota Statutes 2016, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. **Dental services.** (a) Medical assistance covers dental services.

(b) Medical assistance dental coverage for nonpregnant adults is limited to the following services:

(1) comprehensive exams, limited to once every five years;

(2) periodic exams, limited to one per year;

(3) limited exams;

(4) bitewing x-rays, limited to one per year;

(5) periapical x-rays;

(6) panoramic x-rays, limited to one every five years except (1) when medically necessary for the diagnosis and follow-up of oral and maxillofacial pathology and trauma or (2) once every two years for patients who cannot cooperate for intraoral film due to a developmental disability or medical condition that does not allow for intraoral film placement;

(7) prophylaxis, limited to one per year;

(8) application of fluoride varnish, limited to one per year;

(9) posterior fillings, all at the amalgam rate;

(10) anterior fillings;

(11) endodontics, limited to root canals on the anterior and premolars only;

(12) removable prostheses, each dental arch limited to one every six years;

(13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;

(14) palliative treatment and sedative fillings for relief of pain; and

(15) full-mouth debridement, limited to one every five years.

(c) In addition to the services specified in paragraph (b), medical assistance covers the following services for adults, if provided in an outpatient hospital setting or freestanding ambulatory surgical center as part of outpatient dental surgery:

(1) periodontics, limited to periodontal scaling and root planing once every two years;

(2) general anesthesia; and

(3) full-mouth survey once every five years.

(d) Medical assistance covers medically necessary dental services for children and pregnant women. The following guidelines apply:

(1) posterior fillings are paid at the amalgam rate;

(2) application of sealants are covered once every five years per permanent molar for children only;

(3) application of fluoride varnish is covered once every six months; and

(4) orthodontia is eligible for coverage for children only.

(e) In addition to the services specified in paragraphs (b) and (c), medical assistance covers the following services for adults:

(1) house calls or extended care facility calls for on-site delivery of covered services;

(2) behavioral management when additional staff time is required to accommodate behavioral challenges and sedation is not used;

(3) oral or IV sedation, if the covered dental service cannot be performed safely without it or would otherwise require the service to be performed under general anesthesia in a hospital or surgical center; and

(4) prophylaxis, in accordance with an appropriate individualized treatment plan, but no more than four times per year.

(f) The commissioner shall not require prior authorization for the services included in paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing

plans from requiring prior authorization for the services included in paragraph (e), clauses (1) to (3), when provided under sections 256B.69~~, 256B.692,~~ and 256L.12.

Sec. 14. Minnesota Statutes 2016, section 256B.0631, subdivision 1, is amended to read:

Subdivision 1. **Cost-sharing.** (a) Except as provided in subdivision 2, the medical assistance benefit plan shall include the following cost-sharing for all recipients, effective for services provided on or after September 1, 2011:

(1) $3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $3.50 for nonemergency visits to a hospital-based emergency room, except that this co-payment shall be increased to $20 upon federal approval;

(3) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $12 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness;

(4) a family deductible equal to $2.75 per month per family and adjusted annually by the percentage increase in the medical care component of the CPI-U for the period of September to September of the preceding calendar year, rounded to the next higher five-cent increment; and

(5) total monthly cost-sharing must not exceed five percent of family income. For purposes of this paragraph, family income is the total earned and unearned income of the individual and the individual's spouse, if the spouse is enrolled in medical assistance and also subject to the five percent limit on cost-sharing. This paragraph does not apply to premiums charged to individuals described under section 256B.057, subdivision 9.

(b) Recipients of medical assistance are responsible for all co-payments and deductibles in this subdivision.

(c) Notwithstanding paragraph (b), the commissioner, through the contracting process under ~~sections~~ section 256B.69 ~~and 256B.692~~, may allow managed care plans and county-based purchasing plans to waive the family deductible under paragraph (a), clause (4). The value of the family deductible shall not be included in the capitation payment to managed care plans and county-based purchasing plans. Managed care plans and

county-based purchasing plans shall certify annually to the commissioner the dollar value of the family deductible.

(d) Notwithstanding paragraph (b), the commissioner may waive the collection of the family deductible described under paragraph (a), clause (4), from individuals and allow long-term care and waivered service providers to assume responsibility for payment.

(e) Notwithstanding paragraph (b), the commissioner, through the contracting process under section 256B.0756 shall allow the pilot program in Hennepin County to waive co-payments. The value of the co-payments shall not be included in the capitation payment amount to the integrated health care delivery networks under the pilot program.

Sec. 15. Minnesota Statutes 2016, section 256B.37, subdivision 2, is amended to read:

Subd. 2. **Civil action for recovery.** To recover under this section, the attorney general may institute or join a civil action to enforce the subrogation rights of the commissioner established under this section.

Any ~~prepaid health~~ managed care plan or county-based purchasing plan providing services under sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement, section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under section 245.493; demonstration projects for persons with disabilities under section 256B.77; or nursing homes under the alternative payment demonstration project under section 256B.434~~; or the county-based purchasing entity providing services under section 256B.692~~ may retain legal representation to enforce the subrogation rights created under this section or, if no action has been brought, may initiate and prosecute an independent action on their behalf against a person, firm, or corporation that may be liable to the person to whom the care or payment was furnished.

Sec. 16. Minnesota Statutes 2016, 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. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

(b) A ~~prepaid health~~ managed care plan or county-based purchasing 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) The commissioner shall withhold five percent of ~~managed care plan~~ the capitation payments paid to a managed care plan or county-based purchasing plan 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. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. 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 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) 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.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent

year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was 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 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 medical assistance and MinnesotaCare 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.

(f) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous calendar year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 or county-based purchasing plan

demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was 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 shall continue until there is a 25 percent reduction in the hospital admission rate compared to the hospital admission rates in calendar year 2011, as determined by the commissioner. The hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (g). Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in the subsequent hospitalization rate was 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 must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(h) 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~~ the capitation 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, 2014, the commissioner shall withhold three percent of ~~managed care plan~~ the capitation 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) 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.

(k) Contracts between the commissioner and a ~~prepaid health~~ managed care plan or county-based purchasing plan are exempt from the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and 7.

(l) The return of the withhold under paragraphs (h) and (i) is not subject to the requirements of paragraph (c).

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public health care programs. Subcontractor agreements determined to be material, as defined by the commissioner after taking into account state contracting and relevant statutory requirements, must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, consideration, payment terms, scope, duration of the contract, and how the subcontractor services relate to state public health care programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

Sec. 17. Minnesota Statutes 2016, section 256B.69, subdivision 5i, is amended to read:

Subd. 5i. **Administrative expenses.** (a) Administrative costs paid to managed care plans and county-based purchasing plans under this section~~, section 256B.692,~~ and section 256L.12 must not exceed 6.6 percent of total payments made to all managed care plans and county-based purchasing plans in aggregate across all state public health care programs, based on payments expected to be made at the beginning of each calendar year. The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include premium taxes paid under section 297I.05, subdivision 5, provider surcharges paid under section 256.9657, subdivision 3, and health insurance fees under section 9010 of the Affordable Care Act.

(b) The following expenses are not allowable administrative expenses for rate-setting purposes under this section:

(1) charitable contributions made by the managed care plan or the county-based purchasing plan;

(2) compensation of individuals within the organization in excess of $200,000 such that the allocation of compensation for an individual across all state public health care programs in total cannot exceed $200,000;

(3) any penalties or fines assessed against the managed care plan or county-based purchasing plan;

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan, including but not limited to costs to promote the managed care or county-based purchasing plan, costs of facilities used for special events, and costs of displays, demonstrations, donations, and promotional items such as memorabilia, models, gifts, and souvenirs. The commissioner may classify an item listed in this clause as an allowable administrative expense for rate-setting purposes, if the commissioner determines that the expense is incidental to an activity related to state public health care programs that is an allowable cost for purposes of rate setting;

(5) any lobbying and political activities, events, or contributions;

(6) administrative expenses related to the provision of services not covered under the state plan or waiver;

(7) alcoholic beverages and related costs;

(8) membership in any social, dining, or country club or organization; and

(9) entertainment, including amusement, diversion, and social activities, and any costs directly associated with these costs, including but not limited to tickets to shows or sporting events, meals, lodging, rentals, transportation, and gratuities.

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits. Charitable contributions under clause (1) include payments for or to any organization or entity selected by the managed care plan or county-based purchasing plan that is operated for charitable, educational, political, religious, or scientific purposes, that are not related to medical and administrative services covered under state public health care programs.

(c) Payments to a quality improvement organization are an allowable administrative expense for rate-setting purposes under this section, to the extent they are allocated to a state public health care program and approved by the commissioner.

(d) Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public health care program when the cost can be specifically identified with and benefits the individual state public health care program. For administrative services expensed to the state's public health care programs, managed care plans and county-based purchasing plans must clearly identify and separately record expense items listed under paragraph (b) in their accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public health care programs.

(e) Notwithstanding paragraph (a), the commissioner shall reduce administrative expenses paid to managed care plans and county-based purchasing plans by .50 of a percentage point for contracts beginning January 1, 2016, and ending December 31, 2017. To meet the administrative reductions under this paragraph, the commissioner may reduce or eliminate administrative requirements, exclude additional unallowable administrative expenses identified under this section and resulting from the financial audits conducted under subdivision 9d, and utilize competitive bidding to gain efficiencies through economies of scale from increased enrollment. If the total reduction cannot be achieved through administrative reduction, the commissioner may limit total rate increases on payments to managed care plans and county-based purchasing plans.

Sec. 18. Minnesota Statutes 2016, section 256B.69, subdivision 6b, is amended to read:

Subd. 6b. **Home and community-based waiver services.** (a) For individuals enrolled in the Minnesota senior health options project authorized under subdivision 23, elderly

waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(b) For individuals under age 65 enrolled in demonstrations authorized under subdivision 23, home and community-based waiver services shall be covered according to the terms and conditions of the federal agreement governing that demonstration project.

(c) The commissioner of human services shall issue requests for proposals for collaborative service models between counties and managed care organizations to integrate the home and community-based elderly waiver services and additional nursing home services into the prepaid medical assistance program.

(d) Notwithstanding Minnesota Rules, part 9500.1457, subpart 1, item C, elderly waiver services shall be covered statewide under the prepaid medical assistance program for all individuals who are eligible according to section 256B.0915. The commissioner may develop a schedule to phase in implementation of these waiver services, including collaborative service models under paragraph (c). The commissioner shall phase in implementation beginning with those counties participating ~~under section 256B.692~~ in a county-based purchasing plan, and those counties where a viable collaborative service model has been developed. In consultation with counties and all managed care organizations that have expressed an interest in participating in collaborative service models, the commissioner shall evaluate the models. The commissioner shall consider the evaluation in selecting the most appropriate models for statewide implementation.

Sec. 19. Minnesota Statutes 2016, section 256B.69, subdivision 9a, is amended to read:

Subd. 9a. **Administrative expense reporting.** Within the limit of available appropriations, the commissioner shall work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported to the commissioner of health by managed care plans under section 62D.08 and county-based purchasing plans under section ~~256B.692~~ 62W.03, provided that such data are consistent with guidelines and standards for administrative spending that are developed by the commissioner of health, and reported to the legislature under Laws 2008, chapter 364, section 12. Data provided to the commissioner under this subdivision are nonpublic data as defined under section 13.02.

Sec. 20. Minnesota Statutes 2016, section 256B.69, subdivision 9c, is amended to read:

Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect detailed data regarding financials, provider payments, provider rate methodologies, and other data

as determined by the commissioner. The commissioner, in consultation with the commissioners of health and commerce, and in consultation with managed care plans and county-based purchasing plans, 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 under this section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure that the data collection is implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and streamline data collection in order to reduce public and private sector administrative costs. Nothing in this subdivision shall allow release of information that is nonpublic data pursuant to section 13.02.

(b) Effective January 1, 2014, each managed care and county-based purchasing plan must quarterly provide to the commissioner the following information on state public programs, in the form and manner specified by the commissioner, according to guidelines developed by the commissioner in consultation with managed care plans and county-based purchasing plans under contract:

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

(7) utilization reports that summarize utilization and unit cost information by program for hospitalization services, outpatient services, physician services, and other medical services;

(8) pharmaceutical statistics by program and population group for measures of price and utilization of pharmaceutical services;

(9) subcapitation expenses by population group;

(10) third-party payments by program;

(11) all new, active, and closed subrogation cases by program;

(12) all new, active, and closed fraud and abuse cases by program;

(13) medical loss ratios by program;

(14) administrative expenses by category and subcategory by program that reconcile to other state and federal regulatory agencies, including Minnesota Supplement Report #1A;

(15) revenues by program, including investment income;

(16) nonadministrative service payments, provider payments, and reimbursement rates by provider type or service category, by program, paid by the managed care plan or county-based purchasing 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, including but not limited to:

(i) individual-level provider payment and reimbursement rate data;

(ii) provider reimbursement rate methodologies by provider type, by program, including a description of alternative payment arrangements and payments outside the claims process;

(iii) data on implementation of legislatively mandated provider rate changes; and

(iv) individual-level provider payment and reimbursement rate data and plan-specific provider reimbursement rate methodologies by provider type, by program, including alternative payment arrangements and payments outside the claims process, provided to the commissioner under this subdivision are nonpublic data as defined in section 13.02;

(17) data on the amount of reinsurance or transfer of risk by program; and

(18) contribution to reserve, by program.

(c) In the event a report is published or released based on data provided under this subdivision, the commissioner shall provide the report to managed care plans and county-based purchasing plans 15 days prior to the publication or release of the report. Managed care plans and county-based purchasing plans shall have 15 days to review the report and provide comment to the commissioner.

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report, and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

(d) Managed care plans and county-based purchasing plans shall certify to the commissioner for the purpose of financial reporting for state public health care programs under this subdivision that costs reported for state public health care programs include:

(1) only services covered under the state plan and waivers, and related allowable administrative expenses; and

(2) the dollar value of unallowable and nonstate plan services, including both medical and administrative expenditures, that have been excluded.

Sec. 21. Minnesota Statutes 2016, section 256B.69, subdivision 9d, is amended to read:

Subd. 9d. **Financial and quality assurance audits.** (a) The commissioner shall require, in the request for bids and resulting contracts with managed care plans and county-based purchasing plans under this section ~~and section 256B.692~~, that each managed care plan and county-based purchasing plan submit to and fully cooperate with the independent third-party financial audits by the legislative auditor under subdivision 9e of the information required under subdivision 9c, paragraph (b). Each contract with a managed care plan or county-based purchasing plan under this section ~~or section 256B.692~~ must provide the commissioner, the legislative auditor, and vendors contracting with the legislative auditor, access to all data required to complete audits under subdivision 9e.

(b) Each managed care plan and county-based purchasing plan providing services under this section shall provide to the commissioner biweekly encounter data and claims data for state public health care programs and shall participate in a quality assurance program that verifies the timeliness, completeness, accuracy, and consistency of the data provided. The commissioner shall develop written protocols for the quality assurance program and shall make the protocols publicly available. The commissioner shall contract for an independent third-party audit to evaluate the quality assurance protocols as to the capacity of the protocols to ensure complete and accurate data and to evaluate the commissioner's implementation of the protocols.

(c) Upon completion of the evaluation under paragraph (b), the commissioner shall provide copies of the report to the legislative auditor and the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and financing.

(d) Any actuary under contract with the commissioner to provide actuarial services must meet the independence requirements under the professional code for fellows in the Society of Actuaries and must not have provided actuarial services to a managed care plan or county-based purchasing plan that is under contract with the commissioner pursuant to this

section ~~and section 256B.692~~ during the period in which the actuarial services are being provided. An actuary or actuarial firm meeting the requirements of this paragraph must certify and attest to the rates paid to the managed care plans and county-based purchasing plans under this section ~~and section 256B.692~~, and the certification and attestation must be auditable.

(e) The commissioner, to the extent of available funding, shall conduct ad hoc audits of state public health care program administrative and medical expenses reported by managed care plans and county-based purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public health care programs. These audits also must monitor compliance with data and financial report certification requirements established by the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision. The commissioner shall report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 1, 2016, and each February 1 thereafter, the number of ad hoc audits conducted in the past calendar year and the results of these audits.

(f) Nothing in this subdivision shall allow the release of information that is nonpublic data pursuant to section 13.02.

Sec. 22. Minnesota Statutes 2016, section 256B.69, subdivision 26, is amended to read:

Subd. 26. **American Indian recipients.** (a) For American Indian recipients of medical assistance who are required to enroll with a demonstration provider under subdivision 4 ~~or in a county-based purchasing entity, if applicable, under section 256B.692~~, medical assistance shall cover health care services provided at Indian health services facilities and facilities operated by a tribe or tribal organization under funding authorized by United States Code, title 25, sections 450f to 450n, or title III of the Indian Self-Determination and Education Assistance Act, Public Law 93-638, if those services would otherwise be covered under section 256B.0625. Payments for services provided under this subdivision shall be made on a fee-for-service basis, and may, at the option of the tribe or tribal organization, be made according to rates authorized under sections 256.969, subdivision 16, and 256B.0625, subdivision 34. Implementation of this purchasing model is contingent on federal approval.

(b) The commissioner of human services, in consultation with the tribal governments, shall develop a plan for tribes to assist in the enrollment process for American Indian recipients enrolled in the prepaid medical assistance program under this section. This plan also shall address how tribes will be included in ensuring the coordination of care for American Indian recipients between Indian health service or tribal providers and other providers.

(c) For purposes of this subdivision, "American Indian" has the meaning given to persons to whom services will be provided for in Code of Federal Regulations, title 42, section 36.12.

Sec. 23. Minnesota Statutes 2017 Supplement, section 256B.6925, subdivision 4, is amended to read:

Subd. 4. **Language and accessibility standards.** (a) Managed care contracts entered into under section 256B.69~~, 256B.692,~~ or 256L.12~~,~~ must require a managed care ~~organization~~ plan or county-based purchasing plan to provide language assistance, and auxiliary aids and services, if requested, to ensure access to a managed care organization's programs and services, as required under United States Code, title 42, sections 18116 and 2000d, and any other federal regulations or guidance from the United States Department of Health and Human Services.

(b) The commissioner shall establish a methodology to identify the prevalent non-English languages spoken by enrollees and potential enrollees throughout Minnesota and in each managed care organization's service area.

(c) The commissioner shall ensure that oral interpretation is provided in all languages and written interpretation is provided in each prevalent non-English language, and that both are available to enrollees and potential enrollees free of charge. Oral interpretation services shall include the use of auxiliary aids, TTY/TDY, and American sign language.

(d) All written materials that target potential enrollees and are provided to enrollees, including the provider directory, enrollee handbook, appeals and grievance notices, and denial and termination notices, must:

(1) use at least 12-point font;

(2) be written at a 7th grade reading level;

(3) be available in alternative formats and through auxiliary aids and services that consider the special needs of the enrollee, including an enrollee with a disability or limited English proficiency;

(4) use taglines that consist of short statements in each of the prevalent non-English languages, in an 18-point font, that explain the availability of language interpreter services free of charge; and

(5) explain how to request auxiliary aids and services, including the provision of the materials in alternative formats and the TTY/TDY telephone number of the managed care organization's customer service unit and the department's enrollee support system.

(e) For purposes of this subdivision, "prevalent non-English language" means a non-English language that is determined by the commissioner to be spoken by a significant number or percentage of potential enrollees and enrollees with limited proficiency in English.

Sec. 24. Minnesota Statutes 2016, section 256B.694, is amended to read:

256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.

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 enrolled in state public health care programs, 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 ~~sections~~ section 256B.69 ~~and 256B.692~~, are satisfied.

Sec. 25. Minnesota Statutes 2016, section 256B.756, subdivision 3, is amended to read:

Subd. 3. **Health plans.** Payments to managed care and county-based purchasing plans under ~~sections~~ section 256B.69~~, 256B.692,~~ or 256L.12 shall be reduced for services provided on or after October 1, 2009, to reflect the adjustments in subdivision 1.

Sec. 26. Minnesota Statutes 2017 Supplement, section 256B.76, subdivision 1, is amended to read:

Subdivision 1. **Physician reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for physician services as follows:

(1) payment for level one Centers for Medicare and Medicaid Services' common procedural coding system codes titled "office and other outpatient services," "preventive medicine new and established patient," "delivery, antepartum, and postpartum care," "critical care," cesarean delivery and pharmacologic management provided to psychiatric patients,

and level three codes for enhanced services for prenatal high risk, shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992;

(2) payments for all other services shall be paid at the lower of (i) submitted charges, or (ii) 15.4 percent above the rate in effect on June 30, 1992; and

(3) all physician rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases except that payment rates for home health agency services shall be the rates in effect on September 30, 1992.

(b) Effective for services rendered on or after January 1, 2000, payment rates for physician and professional services shall be increased by three percent over the rates in effect on December 31, 1999, except for home health agency and family planning agency services. The increases in this paragraph shall be implemented January 1, 2000, for managed care.

(c) Effective for services rendered on or after July 1, 2009, payment rates for physician and professional services shall be reduced by five percent, except that for the period July 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical assistance and general assistance medical care programs, over the rates in effect on June 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other outpatient visits, preventive medicine visits and family planning visits billed by physicians, advanced practice nurses, or physician assistants in a family planning agency or in one of the following primary care practices: general practice, general internal medicine, general pediatrics, general geriatrics, and family medicine. This reduction and the reductions in paragraph (d) do not apply to federally qualified health centers, rural health centers, and Indian health services. Effective October 1, 2009, payments made to managed care plans and county-based purchasing plans under sections 256B.69~~, 256B.692,~~ and 256L.12 shall reflect the payment reduction described in this paragraph.

(d) Effective for services rendered on or after July 1, 2010, payment rates for physician and professional services shall be reduced an additional seven percent over the five percent reduction in rates described in paragraph (c). This additional reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services provided on or after July 1, 2010. This additional reduction does not apply to physician services billed by a psychiatrist or an advanced practice nurse with a specialty in mental health. Effective October 1, 2010, payments made to managed care plans and county-based purchasing plans under sections 256B.69~~, 256B.692,~~ and 256L.12 shall reflect the payment reduction described in this paragraph.

(e) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for physician and professional services shall be reduced three percent from the rates in effect on August 31, 2011. This reduction does not apply to physical therapy services, occupational therapy services, and speech pathology and related services.

(f) Effective for services rendered on or after September 1, 2014, payment rates for physician and professional services, including physical therapy, occupational therapy, speech pathology, and mental health services shall be increased by five percent from the rates in effect on August 31, 2014. In calculating this rate increase, the commissioner shall not include in the base rate for August 31, 2014, the rate increase provided under section 256B.76, subdivision 7. This increase does not apply to federally qualified health centers, rural health centers, and Indian health services. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(g) Effective for services rendered on or after July 1, 2015, payment rates for physical therapy, occupational therapy, and speech pathology and related services provided by a hospital meeting the criteria specified in section 62Q.19, subdivision 1, paragraph (a), clause (4), shall be increased by 90 percent from the rates in effect on June 30, 2015. Payments made to managed care plans and county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

(h) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

Sec. 27. Minnesota Statutes 2017 Supplement, section 256B.76, subdivision 2, is amended to read:

Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October 1, 1992, the commissioner shall make payments for dental services as follows:

(1) dental services shall be paid at the lower of (i) submitted charges, or (ii) 25 percent above the rate in effect on June 30, 1992; and

(2) dental rates shall be converted from the 50th percentile of 1982 to the 50th percentile of 1989, less the percent in aggregate necessary to equal the above increases.

(b) Beginning October 1, 1999, the payment for tooth sealants and fluoride treatments shall be the lower of (1) submitted charge, or (2) 80 percent of median 1997 charges.

(c) Effective for services rendered on or after January 1, 2000, payment rates for dental services shall be increased by three percent over the rates in effect on December 31, 1999.

(d) Effective for services provided on or after January 1, 2002, payment for diagnostic examinations and dental x-rays provided to children under age 21 shall be the lower of (1) the submitted charge, or (2) 85 percent of median 1999 charges.

(e) The increases listed in paragraphs (b) and (c) shall be implemented January 1, 2000, for managed care.

(f) Effective for dental services rendered on or after October 1, 2010, by a state-operated dental clinic, payment shall be paid on a reasonable cost basis that is based on the Medicare principles of reimbursement. This payment shall be effective for services rendered on or after January 1, 2011, to recipients enrolled in managed care plans or county-based purchasing plans.

(g) Beginning in fiscal year 2011, if the payments to state-operated dental clinics in paragraph (f), including state and federal shares, are less than $1,850,000 per fiscal year, a supplemental state payment equal to the difference between the total payments in paragraph (f) and $1,850,000 shall be paid from the general fund to state-operated services for the operation of the dental clinics.

(h) If the cost-based payment system for state-operated dental clinics described in paragraph (f) does not receive federal approval, then state-operated dental clinics shall be designated as critical access dental providers under subdivision 4, paragraph (b), and shall receive the critical access dental reimbursement rate as described under subdivision 4, paragraph (a).

(i) Effective for services rendered on or after September 1, 2011, through June 30, 2013, payment rates for dental services shall be reduced by three percent. This reduction does not apply to state-operated dental clinics in paragraph (f).

(j) Effective for services rendered on or after January 1, 2014, payment rates for dental services shall be increased by five percent from the rates in effect on December 31, 2013. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2014, payments made to managed care plans and county-based purchasing plans under sections 256B.69~~, 256B.692,~~ and 256L.12 shall reflect the payment increase described in this paragraph.

(k) Effective for services rendered on or after July 1, 2015, through December 31, 2016, the commissioner shall increase payment rates for services furnished by dental providers located outside of the seven-county metropolitan area by the maximum percentage possible above the rates in effect on June 30, 2015, while remaining within the limits of funding

appropriated for this purpose. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, and Indian health services. Effective January 1, 2016, through December 31, 2016, payments to managed care plans and county-based purchasing plans under ~~sections~~ section 256B.69 ~~and 256B.692~~ shall reflect the payment increase described in this paragraph. The commissioner shall require managed care and county-based purchasing plans to pass on the full amount of the increase, in the form of higher payment rates to dental providers located outside of the seven-county metropolitan area.

(l) Effective for services provided on or after January 1, 2017, the commissioner shall increase payment rates by 9.65 percent for dental services provided outside of the seven-county metropolitan area. This increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health services. Effective January 1, 2017, payments to managed care plans and county-based purchasing plans under ~~sections~~ section 256B.69 ~~and 256B.692~~ shall reflect the payment increase described in this paragraph.

(m) Effective for services provided on or after July 1, 2017, the commissioner shall increase payment rates by 23.8 percent for dental services provided to enrollees under the age of 21. This rate increase does not apply to state-operated dental clinics in paragraph (f), federally qualified health centers, rural health centers, or Indian health centers. This rate increase does not apply to managed care plans and county-based purchasing plans.

Sec. 28. Minnesota Statutes 2017 Supplement, section 256B.761, is amended to read:

256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.

(a) Effective for services rendered on or after July 1, 2001, payment for medication management provided to psychiatric patients, outpatient mental health services, day treatment services, home-based mental health services, and family community support services shall be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of 1999 charges.

(b) Effective July 1, 2001, the medical assistance rates for outpatient mental health services provided by an entity that operates: (1) a Medicare-certified comprehensive outpatient rehabilitation facility; and (2) a facility that was certified prior to January 1, 1993, with at least 33 percent of the clients receiving rehabilitation services in the most recent calendar year who are medical assistance recipients, will be increased by 38 percent, when those services are provided within the comprehensive outpatient rehabilitation facility and provided to residents of nursing facilities owned by the entity.

(c) The commissioner shall establish three levels of payment for mental health diagnostic assessment, based on three levels of complexity. The aggregate payment under the tiered rates must not exceed the projected aggregate payments for mental health diagnostic assessment under the previous single rate. The new rate structure is effective January 1, 2011, or upon federal approval, whichever is later.

(d) In addition to rate increases otherwise provided, the commissioner may restructure coverage policy and rates to improve access to adult rehabilitative mental health services under section 256B.0623 and related mental health support services under section 256B.021, subdivision 4, paragraph (f), clause (2). For state fiscal years 2015 and 2016, the projected state share of increased costs due to this paragraph is transferred from adult mental health grants under sections 245.4661 and 256E.12. The transfer for fiscal year 2016 is a permanent base adjustment for subsequent fiscal years. Payments made to managed care plans and county-based purchasing plans under sections 256B.69~~, 256B.692,~~ and 256L.12 shall reflect the rate changes described in this paragraph.

(e) Any ratables effective before July 1, 2015, do not apply to autism early intensive intervention benefits described in section 256B.0949.

Sec. 29. Minnesota Statutes 2016, section 256B.77, subdivision 3, is amended to read:

Subd. 3. **Assurances to commissioner of health.** A county authority that elects to participate in a demonstration project for people with disabilities under this section is not required to obtain a certificate of authority under chapter 62D or 62N. A county authority that elects to participate in a demonstration project for people with disabilities under this section must assure the commissioner of health that the requirements of chapters 62D ~~and~~, 62N, and ~~section 256B.692, subdivision 2,~~ 62W are met. All enforcement and rulemaking powers available under chapters 62D, 62J, 62M, 62N, and 62Q are granted to the commissioner of health with respect to the county authorities that contract with the commissioner to purchase services in a demonstration project for people with disabilities under this section.

Sec. 30. Minnesota Statutes 2016, section 256L.01, subdivision 7, is amended to read:

Subd. 7. **Participating entity.** "Participating entity" means a health carrier as defined in section 62A.01, subdivision 2; a county-based purchasing ~~plan established~~ organization operating under ~~section 256B.692~~ chapter 62W; an accountable care organization or other entity operating a health care delivery systems demonstration project authorized under section 256B.0755; an entity operating a county integrated health care delivery network

pilot project authorized under section 256B.0756; or a network of health care providers established to offer services under MinnesotaCare.

Sec. 31. Minnesota Statutes 2016, 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. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions, when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. 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, through December 31, 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. Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate was 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 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 medical assistance and MinnesotaCare 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.

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than five percent of the plan's hospital admission rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69,

subdivisions 23 and 28, compared to the previous calendar year, until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization rate was 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 shall continue until there is a 25 percent reduction in the hospitals admission rate compared to the hospital admission rate for calendar year 2011 as determined by the commissioner. Hospitals shall cooperate with the 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 hospital admissions in this performance target do not include the admissions applicable to the subsequent hospital admission performance target under paragraph (f).

(f) Effective for services provided on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (b) a reduction in the plan's hospitalization rate for a subsequent hospitalization within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospital admissions rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in section 256B.69, subdivisions 23 and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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 or county-based purchasing plan demonstrates to the satisfaction of the commissioner that a reduction in the subsequent hospitalization rate was 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 must continue for each consecutive contract period until the plan's subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall accept payment withholds that must be returned to the hospitals if the performance target is achieved.

(g) 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.

Sec. 32. Minnesota Statutes 2016, section 256L.121, subdivision 3, is amended to read:

Subd. 3. **Coordination with state-administered health programs.** The commissioner shall coordinate the administration of the MinnesotaCare program with medical assistance to maximize efficiency and improve the continuity of care. This includes, but is not limited to:

(1) establishing geographic areas for MinnesotaCare that are consistent with the geographic areas of the medical assistance program, within which participating entities may offer health plans;

(2) requiring, as a condition of participation in MinnesotaCare, participating entities to also participate in the medical assistance program;

(3) complying with sections 256B.69, subdivision 3a~~; 256B.692, subdivision 1;~~, and 256B.694~~,~~ when contracting with MinnesotaCare participating entities;

(4) providing MinnesotaCare enrollees, to the extent possible, with the option to remain in the same health plan and provider network, if they later become eligible for medical assistance or coverage through MNsure and if, in the case of becoming eligible for medical assistance, the enrollee's MinnesotaCare health plan is also a medical assistance health plan in the enrollee's county of residence; and

(5) establishing requirements and criteria for selection that ensure that covered health care services will be coordinated with local public health services, social services, long-term care services, mental health services, and other local services affecting enrollees' health, access, and quality of care.

APPENDIX
Article locations in SF3252-0

256B.692 COUNTY-BASED PURCHASING.

Subdivision 1. **In general.** County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

Subd. 2. **Duties of commissioner of health.** (a) Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance 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 services under this section must satisfy the commissioner of health that the requirements for assurance of consumer protection, provider protection, and fiscal solvency of chapter 62D, applicable to health maintenance organizations will be met according to the following schedule:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year.

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

Subd. 3. **Requirements of the county board.** A county board that intends to purchase or provide health care under this section, which may include purchasing all or part of these services from health plans or individual providers on a fee-for-service basis, or providing these services directly, must demonstrate the ability to follow and agree to the following requirements:

(1) purchase all covered services for a fixed payment from the state that does not exceed the estimated state and federal cost that would have occurred under the prepaid medical assistance program;

(2) ensure that covered services are accessible to all enrollees and that enrollees have a reasonable choice of providers, health plans, or networks when possible. If the county is also a provider of service, the county board shall develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers, which meet the same quality and cost requirements are available;

(3) issue payments to participating vendors or networks in a timely manner;

(4) establish a process to ensure and improve the quality of care provided;

(5) provide appropriate quality and other required data in a format required by the state;

(6) provide a system for advocacy, enrollee protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

(7) ensure that the implementation and operation of the Minnesota senior health options demonstration project and the Minnesota disability health options demonstration project, authorized under section 256B.69, subdivision 23, will not be impeded;

(8) ensure that all recipients that are enrolled in the prepaid medical assistance program will be transferred to county-based purchasing without utilizing the department's fee-for-service claims payment system;

(9) ensure that all recipients who are required to participate in county-based purchasing are given sufficient information prior to enrollment in order to make informed decisions; and

(10) ensure that the state and the medical assistance recipients will be held harmless for the payment of obligations incurred by the county if the county, or a health plan providing services on behalf of the county, or a provider participating in county-based purchasing becomes insolvent, and the state has made the payments due to the county under this section.

Subd. 4. **Payments to counties.** The commissioner shall pay counties that are purchasing or providing health care under this section a per capita payment for all enrolled recipients. Payments shall not exceed payments that otherwise would have been paid to health plans under medical assistance for that county or region. This payment is in addition to any administrative allocation to counties for education, enrollment, and advocacy. The state of Minnesota and the United States Department of Health and Human Services are not liable for any costs incurred by a county that exceed the payments to the county made under this subdivision. A county whose costs exceed the payments made by the state, or any affected enrollees or creditors of that county, shall have no rights under chapter 61B or section 62D.181. A county may assign risk for the cost of care to a third party.

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

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

Subd. 5. **County proposals.** (a) A county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final proposal and its implementation.

(b) The county board must submit a final proposal that demonstrates the ability to meet all the requirements of this section.

(c) For a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance program in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

Subd. 6. **Commissioner's authority.** The commissioner may:

(1) reject any preliminary or final proposal that:

(i) substantially fails to meet the requirements of this section, or

(ii) the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state, or

(iii) would substantially impair an enrollee's choice of care systems when reasonable choice is possible, or

(iv) would substantially impair the implementation and operation of the Minnesota senior health options demonstration project authorized under section 256B.69, subdivision 23; and

(2) assume operation of a county's purchasing of health care for enrollees in medical assistance in the event that the contract with the county is terminated.

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel. The panel shall be composed of one designee of the president of the Association of Minnesota Counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

Subd. 8. **Appeals.** A county that conducts county-based purchasing shall be considered to be a prepaid health plan for purposes of section 256.045.

Subd. 9. **Federal approval.** The commissioner shall request any federal waivers and federal approval required to implement this section. County-based purchasing shall not be implemented without obtaining all federal approval required to maintain federal matching funds in the medical assistance program.