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State of Minnesota
HOUSE OF REPRESENTATIVES
NINETIETH SESSION

H. F. No. 3337

03/05/2018 Authored by Albright
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

1.1 A bill for an act
1.2 relating to human services; limiting the extent to which the commissioner can
1.3 renew, modify, or renegotiate contracts with integrated health partnerships and
1.4 managed care organizations; amending Minnesota Statutes 2016, sections
1.5 256B.0755, by adding a subdivision; 256B.69, subdivision 5a.

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

1.7 Section 1. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision
1.8 to read:

1.9 Subd. 9. Integrated health partnership contracts. The commissioner is prohibited
1.10 from renewing, modifying, or renegotiating an integrated health partnership contract, if the
1.11 cost to the state of the renewed, modified, or renegotiated contract would exceed the projected
1.12 cost of that contract, as determined by the assumptions and methodology of the most recent
1.13 forecast, by more than ... percent.

1.14 EFFECTIVE DATE. This section is effective January 1, 2019, and applies to renewed,
1.15 modified, or renegotiated contracts that take effect on or after that date.

1.16 Sec. 2. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

1.17 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and
1.18 section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner
1.19 may issue separate contracts with requirements specific to services to medical assistance
1.20 recipients age 65 and older.

1.21 (b) A prepaid health plan providing covered health services for eligible persons pursuant
1.22 to chapters 256B and 256L is responsible for complying with the terms of its contract with

2.1 the commissioner. Requirements applicable to managed care programs under chapters 256B
2.2 and 256L established after the effective date of a contract with the commissioner take effect
2.3 when the contract is next issued or renewed.

2.4 (c) The commissioner shall withhold five percent of managed care plan payments under
2.5 this section and county-based purchasing plan payments under section 256B.692 for the
2.6 prepaid medical assistance program pending completion of performance targets. Each
2.7 performance target must be quantifiable, objective, measurable, and reasonably attainable,
2.8 except in the case of a performance target based on a federal or state law or rule. Criteria
2.9 for assessment of each performance target must be outlined in writing prior to the contract
2.10 effective date. Clinical or utilization performance targets and their related criteria must
2.11 consider evidence-based research and reasonable interventions when available or applicable
2.12 to the populations served, and must be developed with input from external clinical experts
2.13 and stakeholders, including managed care plans, county-based purchasing plans, and
2.14 providers. The managed care or county-based purchasing plan must demonstrate, to the
2.15 commissioner's satisfaction, that the data submitted regarding attainment of the performance
2.16 target is accurate. The commissioner shall periodically change the administrative measures
2.17 used as performance targets in order to improve plan performance across a broader range
2.18 of administrative services. The performance targets must include measurement of plan
2.19 efforts to contain spending on health care services and administrative activities. The
2.20 commissioner may adopt plan-specific performance targets that take into account factors
2.21 affecting only one plan, including characteristics of the plan's enrollee population. The
2.22 withheld funds must be returned no sooner than July of the following year if performance
2.23 targets in the contract are achieved. The commissioner may exclude special demonstration
2.24 projects under subdivision 23.

2.25 (d) The commissioner shall require that managed care plans use the assessment and
2.26 authorization processes, forms, timelines, standards, documentation, and data reporting
2.27 requirements, protocols, billing processes, and policies consistent with medical assistance
2.28 fee-for-service or the Department of Human Services contract requirements consistent with
2.29 medical assistance fee-for-service or the Department of Human Services contract
2.30 requirements for all personal care assistance services under section 256B.0659.

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

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

3.10 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
3.11 the following calendar year if the managed care plan or county-based purchasing plan
3.12 demonstrates to the satisfaction of the commissioner that a reduction in the utilization rate
3.13 was achieved. The commissioner shall structure the withhold so that the commissioner
3.14 returns a portion of the withheld funds in amounts commensurate with achieved reductions
3.15 in utilization less than the targeted amount.

3.16 The withhold described in this paragraph shall continue for each consecutive contract
3.17 period until the plan's emergency room utilization rate for state health care program enrollees
3.18 is reduced by 25 percent of the plan's emergency room utilization rate for medical assistance
3.19 and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the
3.20 health plans in meeting this performance target and shall accept payment withholds that
3.21 may be returned to the hospitals if the performance target is achieved.

3.22 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
3.23 include as part of the performance targets described in paragraph (c) a reduction in the plan's
3.24 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
3.25 determined by the commissioner. To earn the return of the withhold each year, the managed
3.26 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
3.27 than five percent of the plan's hospital admission rate for medical assistance and
3.28 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
3.29 28, compared to the previous calendar year until the final performance target is reached.
3.30 When measuring performance, the commissioner must consider the difference in health risk
3.31 in a managed care or county-based purchasing plan's membership in the baseline year
3.32 compared to the measurement year, and work with the managed care or county-based
3.33 purchasing plan to account for differences that they agree are significant.

3.34 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
3.35 the following calendar year if the managed care plan or county-based purchasing plan

4.1 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
4.2 rate was achieved. The commissioner shall structure the withhold so that the commissioner
4.3 returns a portion of the withheld funds in amounts commensurate with achieved reductions
4.4 in utilization less than the targeted amount.

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

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

4.21 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
4.22 the following calendar year if the managed care plan or county-based purchasing plan
4.23 demonstrates to the satisfaction of the commissioner that a qualifying reduction in the
4.24 subsequent hospitalization rate was achieved. The commissioner shall structure the withhold
4.25 so that the commissioner returns a portion of the withheld funds in amounts commensurate
4.26 with achieved reductions in utilization less than the targeted amount.

4.27 The withhold described in this paragraph must continue for each consecutive contract
4.28 period until the plan's subsequent hospitalization rate for medical assistance and
4.29 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
4.30 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
4.31 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
4.32 accept payment withholds that must be returned to the hospitals if the performance target
4.33 is achieved.

5.1 (h) Effective for services rendered on or after January 1, 2013, through December 31,
5.2 2013, the commissioner shall withhold 4.5 percent of managed care plan payments under
5.3 this section and county-based purchasing plan payments under section 256B.692 for the
5.4 prepaid medical assistance program. The withheld funds must be returned no sooner than
5.5 July 1 and no later than July 31 of the following year. The commissioner may exclude
5.6 special demonstration projects under subdivision 23.

5.7 (i) Effective for services rendered on or after January 1, 2014, the commissioner shall
5.8 withhold three percent of managed care plan payments under this section and county-based
5.9 purchasing plan payments under section 256B.692 for the prepaid medical assistance
5.10 program. The withheld funds must be returned no sooner than July 1 and no later than July
5.11 31 of the following year. The commissioner may exclude special demonstration projects
5.12 under subdivision 23.

5.13 (j) A managed care plan or a county-based purchasing plan under section 256B.692 may
5.14 include as admitted assets under section 62D.044 any amount withheld under this section
5.15 that is reasonably expected to be returned.

5.16 (k) Contracts between the commissioner and a prepaid health plan are exempt from the
5.17 set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph (a), and
5.18 7.

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

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

5.32 (n) The commissioner is prohibited from renewing, modifying, or renegotiating a managed
5.33 care or county-based purchasing plan contract under this section or section 256L.12, if the
5.34 cost to the state of the renewed, modified, or renegotiated contract would exceed the projected

6.1 cost of that contract, as determined by the assumptions and methodology of the most recent
6.2 forecast, by more than ... percent.

6.3 **EFFECTIVE DATE.** This section is effective January 1, 2019, and applies to renewed,
6.4 modified, or renegotiated contracts that take effect on or after that date.