

This Document can be made available in alternative formats upon request

State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 3706

03/12/2018 Authored by Albright, Backer, Haley, Zerwas, Kiel and others
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

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;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

3.32 (4) comply with the provisions in sections 62J.48, 62J.71 to 62J.73, 62M.01 to 62M.16,
3.33 and all applicable provisions of chapter 62Q, including sections 62Q.075, 62Q.1055,

4.1 62Q.106, 62Q.12, 62Q.135, 62Q.14, 62Q.145, 62Q.19, 62Q.23, paragraph (c), 62Q.43,
4.2 62Q.47, 62Q.50, 62Q.52 to 62Q.56, 62Q.58, and 62Q.68 to 62Q.72;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

6.19 (2) to increase payments to providers;

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

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

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

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

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

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

7.5 Subd. 2. **Notice.** If a county-based purchasing organization elects to offer a county-based
 7.6 purchasing plan in a county or group of counties where a county-based purchasing plan has
 7.7 not been implemented and plans to participate in the procurement process under section
 7.8 256B.69, the county-based purchasing organization must provide notice to the commissioner
 7.9 of human services at least 15 months prior to the termination date of the existing managed
 7.10 care plan contract that covers eligible individuals in that county or group of counties.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.4 ~~(h)~~ (e) The commissioner shall provide a written report under section 3.195 to the chairs
 10.5 of the legislative committees having jurisdiction over human services in the senate and the
 10.6 house of representatives describing in detail the activities undertaken by the commissioner
 10.7 to ensure full compliance with this section. The report must also provide an explanation for
 10.8 any decisions of the commissioner not to accept the recommendations of a county or group
 10.9 of counties required to be consulted under this section. The report must be provided at least
 10.10 30 days prior to the effective date of a new or renewed prepaid or managed care contract
 10.11 in a county.

10.12 Sec. 10. **REPEALER.**

10.13 (a) Minnesota Statutes 2016, sections 256B.692, subdivisions 1, 2, 3, 4, 4a, 5, 7, 8, and
 10.14 9, are repealed.

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

10.16 **ARTICLE 2**

10.17 **CONFORMING CHANGES**

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

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

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

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

11.4 **62A.045 PAYMENTS ON BEHALF OF ENROLLEES IN GOVERNMENT**
11.5 **HEALTH PROGRAMS.**

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

11.13 For the purpose of this section, "health insurer" includes self-insured plans, group health
11.14 plans (as defined in section 607(1) of the Employee Retirement Income Security Act of
11.15 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or
11.16 other parties that are by contract legally responsible to pay a claim for a health-care item
11.17 or service for an individual receiving benefits under paragraph (b).

11.18 (b) No plan offered by a health insurer issued or renewed to provide coverage to a
11.19 Minnesota resident shall contain any provision denying or reducing benefits because services
11.20 are rendered to a person who is eligible for or receiving medical benefits pursuant to title
11.21 XIX of the Social Security Act (Medicaid) in this or any other state; chapter 256 or 256B;
11.22 or services pursuant to section 252.27; 256L.01 to 256L.10; 260B.331, subdivision 2;
11.23 260C.331, subdivision 2; or 393.07, subdivision 1 or 2. No health insurer providing benefits
11.24 under plans covered by this section shall use eligibility for medical programs named in this
11.25 section as an underwriting guideline or reason for nonacceptance of the risk.

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

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

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

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

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

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

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

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

13.1 (b) The enrollee shall be allowed to review the information relied upon in the course of
 13.2 the appeal, present evidence and testimony as part of the appeals process, and receive
 13.3 continued coverage pending the outcome of the appeals process. This paragraph does not
 13.4 apply to managed care plans or county-based purchasing plans serving state public health
 13.5 care program enrollees under section 256B.69, ~~256B.692~~, or chapter 256L, or to
 13.6 grandfathered plans as defined under section 62A.011, subdivision 1c. Nothing in this
 13.7 paragraph shall be construed to limit or restrict the appeal rights of state public health care
 13.8 program enrollees provided under section 256.045 and Code of Federal Regulations, title
 13.9 42, section 438.420(d).

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

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

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

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

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

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

13.28 (e) "Dependent" means an eligible employee's spouse or child who is under the age of
 13.29 26 years.

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

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

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

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

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

14.6 (a) "Health plan" means:

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

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

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

14.10 or

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

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

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

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

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

14.20 (ii) the Minnesota children with special health needs program under sections 144.05 and
 14.21 144.07;

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

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

14.25 (v) developmental disabilities services under chapter 256B;

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

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

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

- 15.1 (ix) Minnesota Comprehensive Children's Mental Health Act under section 245.487;
- 15.2 (x) the community health services grants under sections 145.88 to 145.9266;
- 15.3 (xi) the Local Public Health Act under chapter 145A; and
- 15.4 (xii) the Vulnerable Children and Adults Act, sections 256M.60 to 256M.80;
- 15.5 (2) service provision and funding that can be coordinated through:
- 15.6 (i) the children's mental health collaborative under section 245.493;
- 15.7 (ii) the family services collaborative under section 124D.23;
- 15.8 (iii) the community transition interagency committees under section 125A.22; and
- 15.9 (iv) the interagency early intervention committees under section 125A.259;
- 15.10 (3) financial and other funding programs to be coordinated including medical assistance
- 15.11 under title 42, chapter 7, of the Social Security Act, the MinnesotaCare program under
- 15.12 chapter 256L, Supplemental Social Security Income, Developmental Disabilities Assistance,
- 15.13 and any other employment-related activities associated with the Social Security
- 15.14 Administration; and services provided under a health plan in conformity with an individual
- 15.15 family service plan or an individualized education program or an individual interagency
- 15.16 intervention plan; and
- 15.17 (4) additional appropriate services that local agencies and counties provide on an
- 15.18 individual need basis upon determining eligibility and receiving a request from (i) the school
- 15.19 board or county board and (ii) the child's parent.
- 15.20 (d) "Children with disabilities" has the meaning given in section 125A.02.
- 15.21 (e) A "standardized written plan" means those individual services or programs, with
- 15.22 accompanying funding sources, available through the interagency intervention service
- 15.23 system to an eligible child other than the services or programs described in the child's
- 15.24 individualized education program or the child's individual family service plan.
- 15.25 Sec. 7. Minnesota Statutes 2016, section 245.4682, subdivision 3, is amended to read:
- 15.26 Subd. 3. **Projects for coordination of care.** (a) Consistent with section 256B.69 and
- 15.27 chapter 256L, the commissioner is authorized to solicit, approve, and implement up to three
- 15.28 projects to demonstrate the integration of physical and mental health services within prepaid
- 15.29 health plans and their coordination with social services. The commissioner shall require
- 15.30 that each project be based on locally defined partnerships that include at least one health
- 15.31 maintenance organization, community integrated service network, or accountable provider

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

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

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

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

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

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

16.17 (iv) court-ordered assessments and treatments;

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

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

16.21 (vii) home and community-based waiver services;

16.22 (viii) assistance with finding and maintaining employment;

16.23 (ix) housing; and

16.24 (x) transportation;

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

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

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

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

- 17.1 (iv) risk screening procedures;
- 17.2 (v) health care coordination;
- 17.3 (vi) member services and access to applicable protections and appeal processes;
- 17.4 (vii) specialty provider networks;
- 17.5 (viii) transportation services;
- 17.6 (ix) treatment planning; and
- 17.7 (x) administrative simplification for providers;
- 17.8 (3) begin implementation of the projects no earlier than January 1, 2009, with not more
17.9 than 40 percent of the statewide population included during calendar year 2009 and additional
17.10 counties included in subsequent years;
- 17.11 (4) waive any administrative rule not consistent with the implementation of the projects;
- 17.12 (5) allow potential bidders at least 90 days to respond to the request for proposals; and
- 17.13 (6) conduct an independent evaluation to determine if mental health outcomes have
17.14 improved in that county or counties according to measurable standards designed in
17.15 consultation with the advisory body established under this subdivision and reviewed by the
17.16 State Advisory Council on Mental Health.
- 17.17 (c) Notwithstanding any statute or administrative rule to the contrary, the commissioner
17.18 may enroll all persons eligible for medical assistance with serious mental illness or emotional
17.19 disturbance in the prepaid plan of their choice within the project service area unless:
- 17.20 (1) the individual is eligible for home and community-based services for persons with
17.21 developmental disabilities and related conditions under section 256B.092; or
- 17.22 (2) the individual has a basis for exclusion from the prepaid plan under section 256B.69,
17.23 subdivision 4, other than disability, mental illness, or emotional disturbance.
- 17.24 (d) The commissioner shall involve organizations representing persons with mental
17.25 illness and their families in the development and distribution of information used to educate
17.26 potential enrollees regarding their options for health care and mental health service delivery
17.27 under this subdivision.
- 17.28 (e) If the person described in paragraph (c) does not elect to remain in fee-for-service
17.29 medical assistance, or declines to choose a plan, the commissioner may preferentially assign
17.30 that person to the prepaid plan participating in the preferred integrated network. The

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

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

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

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

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

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

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

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

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

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

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

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

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

19.14 Subdivision 1. **Lien for cost of care.** When the state agency provides, pays for, or
 19.15 becomes liable for medical care, it shall have a lien for the cost of the care upon any and
 19.16 all causes of action or recovery rights under any policy, plan, or contract providing benefits
 19.17 for health care or injury, which accrue to the person to whom the care was furnished, or to
 19.18 the person's legal representatives, as a result of the illness or injuries which necessitated the
 19.19 medical care. For purposes of this section, "state agency" includes ~~prepaid health~~ managed
 19.20 care plans and county-based purchasing plans under contract with the commissioner
 19.21 according to sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement,
 19.22 section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under
 19.23 section 245.493; demonstration projects for persons with disabilities under section 256B.77;
 19.24 and nursing facilities under the alternative payment demonstration project under section
 19.25 256B.434; ~~and county-based purchasing entities under section 256B.692.~~

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

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

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

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

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

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

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

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

20.21 (3) limited exams;

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

20.23 (5) periapical x-rays;

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

20.28 (7) prophylaxis, limited to one per year;

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

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

20.31 (10) anterior fillings;

- 21.1 (11) endodontics, limited to root canals on the anterior and premolars only;
- 21.2 (12) removable prostheses, each dental arch limited to one every six years;
- 21.3 (13) oral surgery, limited to extractions, biopsies, and incision and drainage of abscesses;
- 21.4 (14) palliative treatment and sedative fillings for relief of pain; and
- 21.5 (15) full-mouth debridement, limited to one every five years.
- 21.6 (c) In addition to the services specified in paragraph (b), medical assistance covers the
- 21.7 following services for adults, if provided in an outpatient hospital setting or freestanding
- 21.8 ambulatory surgical center as part of outpatient dental surgery:
- 21.9 (1) periodontics, limited to periodontal scaling and root planing once every two years;
- 21.10 (2) general anesthesia; and
- 21.11 (3) full-mouth survey once every five years.
- 21.12 (d) Medical assistance covers medically necessary dental services for children and
- 21.13 pregnant women. The following guidelines apply:
- 21.14 (1) posterior fillings are paid at the amalgam rate;
- 21.15 (2) application of sealants are covered once every five years per permanent molar for
- 21.16 children only;
- 21.17 (3) application of fluoride varnish is covered once every six months; and
- 21.18 (4) orthodontia is eligible for coverage for children only.
- 21.19 (e) In addition to the services specified in paragraphs (b) and (c), medical assistance
- 21.20 covers the following services for adults:
- 21.21 (1) house calls or extended care facility calls for on-site delivery of covered services;
- 21.22 (2) behavioral management when additional staff time is required to accommodate
- 21.23 behavioral challenges and sedation is not used;
- 21.24 (3) oral or IV sedation, if the covered dental service cannot be performed safely without
- 21.25 it or would otherwise require the service to be performed under general anesthesia in a
- 21.26 hospital or surgical center; and
- 21.27 (4) prophylaxis, in accordance with an appropriate individualized treatment plan, but
- 21.28 no more than four times per year.
- 21.29 (f) The commissioner shall not require prior authorization for the services included in
- 21.30 paragraph (e), clauses (1) to (3), and shall prohibit managed care and county-based purchasing

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

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

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

22.7 (1) \$3 per nonpreventive visit, except as provided in paragraph (b). For purposes of this
22.8 subdivision, a visit means an episode of service which is required because of a recipient's
22.9 symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting
22.10 by a physician or physician assistant, chiropractor, podiatrist, nurse midwife, advanced
22.11 practice nurse, audiologist, optician, or optometrist;

22.12 (2) \$3.50 for nonemergency visits to a hospital-based emergency room, except that this
22.13 co-payment shall be increased to \$20 upon federal approval;

22.14 (3) \$3 per brand-name drug prescription and \$1 per generic drug prescription, subject
22.15 to a \$12 per month maximum for prescription drug co-payments. No co-payments shall
22.16 apply to antipsychotic drugs when used for the treatment of mental illness;

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

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

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

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

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

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

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

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

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

23.14 Any ~~prepaid health~~ managed care plan or county-based purchasing plan providing
23.15 services under sections 256B.69 and 256L.12 and Minnesota Statutes 2009 Supplement,
23.16 section 256D.03, subdivision 4, paragraph (c); children's mental health collaboratives under
23.17 section 245.493; demonstration projects for persons with disabilities under section 256B.77;
23.18 or nursing homes under the alternative payment demonstration project under section
23.19 256B.434; ~~or the county-based purchasing entity providing services under section 256B.692~~
23.20 may retain legal representation to enforce the subrogation rights created under this section
23.21 or, if no action has been brought, may initiate and prosecute an independent action on their
23.22 behalf against a person, firm, or corporation that may be liable to the person to whom the
23.23 care or payment was furnished.

23.24 Sec. 16. Minnesota Statutes 2016, section 256B.69, subdivision 5a, is amended to read:

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

23.29 (b) A ~~prepaid health~~ managed care plan or county-based purchasing plan providing
23.30 covered health services for eligible persons pursuant to chapters 256B and 256L is responsible
23.31 for complying with the terms of its contract with the commissioner. Requirements applicable
23.32 to managed care programs under chapters 256B and 256L established after the effective

24.1 date of a contract with the commissioner take effect when the contract is next issued or
 24.2 renewed.

24.3 (c) The commissioner shall withhold five percent of ~~managed care plan~~ the capitation
 24.4 payments paid to a managed care plan or county-based purchasing plan under this section
 24.5 ~~and county-based purchasing plan payments under section 256B.692~~ for the prepaid medical
 24.6 assistance program pending completion of performance targets. Each performance target
 24.7 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
 24.8 of a performance target based on a federal or state law or rule. Criteria for assessment of
 24.9 each performance target must be outlined in writing prior to the contract effective date.
 24.10 Clinical or utilization performance targets and their related criteria must consider
 24.11 evidence-based research and reasonable interventions when available or applicable to the
 24.12 populations served, and must be developed with input from external clinical experts and
 24.13 stakeholders, including managed care plans, county-based purchasing plans, and providers.
 24.14 The managed care or county-based purchasing plan must demonstrate, to the commissioner's
 24.15 satisfaction, that the data submitted regarding attainment of the performance target is accurate.
 24.16 The commissioner shall periodically change the administrative measures used as performance
 24.17 targets in order to improve plan performance across a broader range of administrative
 24.18 services. The performance targets must include measurement of plan efforts to contain
 24.19 spending on health care services and administrative activities. The commissioner may adopt
 24.20 plan-specific performance targets that take into account factors affecting only one plan,
 24.21 including characteristics of the plan's enrollee population. The withheld funds must be
 24.22 returned no sooner than July of the following year if performance targets in the contract are
 24.23 achieved. The commissioner may exclude special demonstration projects under subdivision
 24.24 23.

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

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

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

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

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

25.22 (f) Effective for services rendered on or after January 1, 2012, the commissioner shall
25.23 include as part of the performance targets described in paragraph (c) a reduction in the plan's
25.24 hospitalization admission rate for medical assistance and MinnesotaCare enrollees, as
25.25 determined by the commissioner. To earn the return of the withhold each year, the managed
25.26 care plan or county-based purchasing plan must achieve a qualifying reduction of no less
25.27 than five percent of the plan's hospital admission rate for medical assistance and
25.28 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
25.29 28, compared to the previous calendar year until the final performance target is reached.
25.30 When measuring performance, the commissioner must consider the difference in health risk
25.31 in a managed care or county-based purchasing plan's membership in the baseline year
25.32 compared to the measurement year, and work with the managed care or county-based
25.33 purchasing plan to account for differences that they agree are significant.

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

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

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

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

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

26.27 The withhold described in this paragraph must continue for each consecutive contract
26.28 period until the plan's subsequent hospitalization rate for medical assistance and
26.29 MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and
26.30 28, is reduced by 25 percent of the plan's subsequent hospitalization rate for calendar year
26.31 2011. Hospitals shall cooperate with the plans in meeting this performance target and shall
26.32 accept payment withholds that must be returned to the hospitals if the performance target
26.33 is achieved.

27.1 (h) Effective for services rendered on or after January 1, 2013, through December 31,
27.2 2013, the commissioner shall withhold 4.5 percent of ~~managed care plan~~ the capitation
27.3 ~~payments under this section and county-based purchasing plan payments under section~~
27.4 ~~256B.692~~ for the prepaid medical assistance program. The withheld funds must be returned
27.5 no sooner than July 1 and no later than July 31 of the following year. The commissioner
27.6 may exclude special demonstration projects under subdivision 23.

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

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

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

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

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

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

28.2 Subd. 5i. **Administrative expenses.** (a) Administrative costs paid to managed care plans
28.3 and county-based purchasing plans under this section, ~~section 256B.692~~, and section 256L.12
28.4 must not exceed 6.6 percent of total payments made to all managed care plans and
28.5 county-based purchasing plans in aggregate across all state public health care programs,
28.6 based on payments expected to be made at the beginning of each calendar year. The
28.7 commissioner may reduce or eliminate administrative requirements to meet the administrative
28.8 cost limit. For purposes of this paragraph, administrative costs do not include premium
28.9 taxes paid under section 297I.05, subdivision 5, provider surcharges paid under section
28.10 256.9657, subdivision 3, and health insurance fees under section 9010 of the Affordable
28.11 Care Act.

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

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

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

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

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

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

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

28.32 (7) alcoholic beverages and related costs;

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

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

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

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

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

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

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

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

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

30.3 (b) For individuals under age 65 enrolled in demonstrations authorized under subdivision
30.4 23, home and community-based waiver services shall be covered according to the terms
30.5 and conditions of the federal agreement governing that demonstration project.

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

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

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

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

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

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

31.1 as determined by the commissioner. The commissioner, in consultation with the
31.2 commissioners of health and commerce, and in consultation with managed care plans and
31.3 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the
31.4 data to be submitted, and shall require managed care and county-based purchasing plans to
31.5 comply with these criteria, definitions, and standards when submitting data under this
31.6 section. In carrying out the responsibilities of this subdivision, the commissioner shall ensure
31.7 that the data collection is implemented in an integrated and coordinated manner that avoids
31.8 unnecessary duplication of effort. To the extent possible, the commissioner shall use existing
31.9 data sources and streamline data collection in order to reduce public and private sector
31.10 administrative costs. Nothing in this subdivision shall allow release of information that is
31.11 nonpublic data pursuant to section 13.02.

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

31.17 (1) an income statement by program;

31.18 (2) financial statement footnotes;

31.19 (3) quarterly profitability by program and population group;

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

31.21 (5) received but unpaid claims report by program;

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

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

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

31.29 (9) subcapitation expenses by population group;

31.30 (10) third-party payments by program;

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

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

- 32.1 (13) medical loss ratios by program;
- 32.2 (14) administrative expenses by category and subcategory by program that reconcile to
32.3 other state and federal regulatory agencies, including Minnesota Supplement Report #1A;
- 32.4 (15) revenues by program, including investment income;
- 32.5 (16) nonadministrative service payments, provider payments, and reimbursement rates
32.6 by provider type or service category, by program, paid by the managed care plan or
32.7 county-based purchasing plan under this section ~~or the county-based purchasing plan under~~
32.8 ~~section 256B.692~~ to providers and vendors for administrative services under contract with
32.9 the plan, including but not limited to:
- 32.10 (i) individual-level provider payment and reimbursement rate data;
- 32.11 (ii) provider reimbursement rate methodologies by provider type, by program, including
32.12 a description of alternative payment arrangements and payments outside the claims process;
- 32.13 (iii) data on implementation of legislatively mandated provider rate changes; and
- 32.14 (iv) individual-level provider payment and reimbursement rate data and plan-specific
32.15 provider reimbursement rate methodologies by provider type, by program, including
32.16 alternative payment arrangements and payments outside the claims process, provided to the
32.17 commissioner under this subdivision are nonpublic data as defined in section 13.02;
- 32.18 (17) data on the amount of reinsurance or transfer of risk by program; and
- 32.19 (18) contribution to reserve, by program.
- 32.20 (c) In the event a report is published or released based on data provided under this
32.21 subdivision, the commissioner shall provide the report to managed care plans and
32.22 county-based purchasing plans 15 days prior to the publication or release of the report.
32.23 Managed care plans and county-based purchasing plans shall have 15 days to review the
32.24 report and provide comment to the commissioner.
- 32.25 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
32.26 end of the previous quarter, except the fourth-quarter report, which shall be submitted by
32.27 April 1 of each year. The fourth-quarter report shall include audited financial statements,
32.28 parent company audited financial statements, an income statement reconciliation report,
32.29 and any other documentation necessary to reconcile the detailed reports to the audited
32.30 financial statements.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

35.7 (c) For purposes of this subdivision, "American Indian" has the meaning given to persons
35.8 to whom services will be provided for in Code of Federal Regulations, title 42, section
35.9 36.12.

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

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

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

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

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

35.29 (1) use at least 12-point font;

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

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

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

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

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

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

36.11 **256B.694 SOLE-SOURCE OR SINGLE-PLAN MANAGED CARE CONTRACT.**

36.12 The commissioner shall consider, and may approve, contracting on a single-health plan
 36.13 basis with county-based purchasing plans, or with other qualified health plans that have
 36.14 coordination arrangements with counties, to serve persons enrolled in state public health
 36.15 care programs, in order to promote better coordination or integration of health care services,
 36.16 social services and other community-based services, provided that all requirements applicable
 36.17 to health plan purchasing, including those in ~~sections~~ section 256B.69 and ~~256B.692~~, are
 36.18 satisfied.

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

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

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

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

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

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

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

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

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

37.13 (c) Effective for services rendered on or after July 1, 2009, payment rates for physician
37.14 and professional services shall be reduced by five percent, except that for the period July
37.15 1, 2009, through June 30, 2010, payment rates shall be reduced by 6.5 percent for the medical
37.16 assistance and general assistance medical care programs, over the rates in effect on June
37.17 30, 2009. This reduction and the reductions in paragraph (d) do not apply to office or other
37.18 outpatient visits, preventive medicine visits and family planning visits billed by physicians,
37.19 advanced practice nurses, or physician assistants in a family planning agency or in one of
37.20 the following primary care practices: general practice, general internal medicine, general
37.21 pediatrics, general geriatrics, and family medicine. This reduction and the reductions in
37.22 paragraph (d) do not apply to federally qualified health centers, rural health centers, and
37.23 Indian health services. Effective October 1, 2009, payments made to managed care plans
37.24 and county-based purchasing plans under sections 256B.69, ~~256B.692~~, and 256L.12 shall
37.25 reflect the payment reduction described in this paragraph.

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

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

38.5 (f) Effective for services rendered on or after September 1, 2014, payment rates for
38.6 physician and professional services, including physical therapy, occupational therapy, speech
38.7 pathology, and mental health services shall be increased by five percent from the rates in
38.8 effect on August 31, 2014. In calculating this rate increase, the commissioner shall not
38.9 include in the base rate for August 31, 2014, the rate increase provided under section
38.10 256B.76, subdivision 7. This increase does not apply to federally qualified health centers,
38.11 rural health centers, and Indian health services. Payments made to managed care plans and
38.12 county-based purchasing plans shall not be adjusted to reflect payments under this paragraph.

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

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

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

38.23 Subd. 2. **Dental reimbursement.** (a) Effective for services rendered on or after October
38.24 1, 1992, the commissioner shall make payments for dental services as follows:

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

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

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

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

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

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

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

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

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

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

39.24 (j) Effective for services rendered on or after January 1, 2014, payment rates for dental
39.25 services shall be increased by five percent from the rates in effect on December 31, 2013.
39.26 This increase does not apply to state-operated dental clinics in paragraph (f), federally
39.27 qualified health centers, rural health centers, and Indian health services. Effective January
39.28 1, 2014, payments made to managed care plans and county-based purchasing plans under
39.29 sections ~~256B.69, 256B.692,~~ and 256L.12 shall reflect the payment increase described in
39.30 this paragraph.

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

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

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

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

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

40.22 **256B.761 REIMBURSEMENT FOR MENTAL HEALTH SERVICES.**

40.23 (a) Effective for services rendered on or after July 1, 2001, payment for medication
 40.24 management provided to psychiatric patients, outpatient mental health services, day treatment
 40.25 services, home-based mental health services, and family community support services shall
 40.26 be paid at the lower of (1) submitted charges, or (2) 75.6 percent of the 50th percentile of
 40.27 1999 charges.

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

41.1 (c) The commissioner shall establish three levels of payment for mental health diagnostic
 41.2 assessment, based on three levels of complexity. The aggregate payment under the tiered
 41.3 rates must not exceed the projected aggregate payments for mental health diagnostic
 41.4 assessment under the previous single rate. The new rate structure is effective January 1,
 41.5 2011, or upon federal approval, whichever is later.

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

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

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

41.18 Subd. 3. **Assurances to commissioner of health.** A county authority that elects to
 41.19 participate in a demonstration project for people with disabilities under this section is not
 41.20 required to obtain a certificate of authority under chapter 62D or 62N. A county authority
 41.21 that elects to participate in a demonstration project for people with disabilities under this
 41.22 section must assure the commissioner of health that the requirements of chapters 62D ~~and~~,
 41.23 62N, and ~~section 256B.692, subdivision 2,~~ 62W are met. All enforcement and rulemaking
 41.24 powers available under chapters 62D, 62J, 62M, 62N, and 62Q are granted to the
 41.25 commissioner of health with respect to the county authorities that contract with the
 41.26 commissioner to purchase services in a demonstration project for people with disabilities
 41.27 under this section.

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

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

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

42.3 Sec. 31. Minnesota Statutes 2016, section 256L.12, subdivision 9, is amended to read:

42.4 Subd. 9. **Rate setting; performance withholds.** (a) Rates will be prospective, per capita,
42.5 where possible. The commissioner may allow health plans to arrange for inpatient hospital
42.6 services on a risk or nonrisk basis. The commissioner shall consult with an independent
42.7 actuary to determine appropriate rates.

42.8 (b) For services rendered on or after January 1, 2004, the commissioner shall withhold
42.9 five percent of managed care plan payments and county-based purchasing plan payments
42.10 under this section pending completion of performance targets. Each performance target
42.11 must be quantifiable, objective, measurable, and reasonably attainable, except in the case
42.12 of a performance target based on a federal or state law or rule. Criteria for assessment of
42.13 each performance target must be outlined in writing prior to the contract effective date.
42.14 Clinical or utilization performance targets and their related criteria must consider
42.15 evidence-based research and reasonable interventions, when available or applicable to the
42.16 populations served, and must be developed with input from external clinical experts and
42.17 stakeholders, including managed care plans, county-based purchasing plans, and providers.
42.18 The managed care plan must demonstrate, to the commissioner's satisfaction, that the data
42.19 submitted regarding attainment of the performance target is accurate. The commissioner
42.20 shall periodically change the administrative measures used as performance targets in order
42.21 to improve plan performance across a broader range of administrative services. The
42.22 performance targets must include measurement of plan efforts to contain spending on health
42.23 care services and administrative activities. The commissioner may adopt plan-specific
42.24 performance targets that take into account factors affecting only one plan, such as
42.25 characteristics of the plan's enrollee population. The withheld funds must be returned no
42.26 sooner than July 1 and no later than July 31 of the following calendar year if performance
42.27 targets in the contract are achieved.

42.28 (c) For services rendered on or after January 1, 2011, the commissioner shall withhold
42.29 an additional three percent of managed care plan or county-based purchasing plan payments
42.30 under this section. The withheld funds must be returned no sooner than July 1 and no later
42.31 than July 31 of the following calendar year. The return of the withhold under this paragraph
42.32 is not subject to the requirements of paragraph (b).

42.33 (d) Effective for services rendered on or after January 1, 2011, through December 31,
42.34 2011, the commissioner shall include as part of the performance targets described in

43.1 paragraph (b) a reduction in the plan's emergency room utilization rate for state health care
43.2 program enrollees by a measurable rate of five percent from the plan's utilization rate for
43.3 the previous calendar year. Effective for services rendered on or after January 1, 2012, the
43.4 commissioner shall include as part of the performance targets described in paragraph (b) a
43.5 reduction in the health plan's emergency department utilization rate for medical assistance
43.6 and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reductions
43.7 shall be based on the health plan's utilization in 2009. To earn the return of the withhold
43.8 each subsequent year, the managed care plan or county-based purchasing plan must achieve
43.9 a qualifying reduction of no less than ten percent of the plan's utilization rate for medical
43.10 assistance and MinnesotaCare enrollees, excluding enrollees in programs described in
43.11 section 256B.69, subdivisions 23 and 28, compared to the previous measurement year, until
43.12 the final performance target is reached. When measuring performance, the commissioner
43.13 must consider the difference in health risk in a managed care or county-based purchasing
43.14 plan's membership in the baseline year compared to the measurement year, and work with
43.15 the managed care or county-based purchasing plan to account for differences that they agree
43.16 are significant.

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

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

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

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

44.6 The withheld funds must be returned no sooner than July 1 and no later than July 31 of
44.7 the following calendar year if the managed care plan or county-based purchasing plan
44.8 demonstrates to the satisfaction of the commissioner that this reduction in the hospitalization
44.9 rate was achieved. The commissioner shall structure the withhold so that the commissioner
44.10 returns a portion of the withheld funds in amounts commensurate with achieved reductions
44.11 in utilization less than the targeted amount.

44.12 The withhold described in this paragraph shall continue until there is a 25 percent
44.13 reduction in the hospitals admission rate compared to the hospital admission rate for calendar
44.14 year 2011 as determined by the commissioner. Hospitals shall cooperate with the plans in
44.15 meeting this performance target and shall accept payment withholds that may be returned
44.16 to the hospitals if the performance target is achieved. The hospital admissions in this
44.17 performance target do not include the admissions applicable to the subsequent hospital
44.18 admission performance target under paragraph (f).

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

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

45.1 The withhold described in this paragraph must continue for each consecutive contract
 45.2 period until the plan's subsequent hospitalization rate for medical assistance and
 45.3 MinnesotaCare enrollees is reduced by 25 percent of the plan's subsequent hospitalization
 45.4 rate for calendar year 2011. Hospitals shall cooperate with the plans in meeting this
 45.5 performance target and shall accept payment withholds that must be returned to the hospitals
 45.6 if the performance target is achieved.

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

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

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

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

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

45.20 (3) complying with sections 256B.69, subdivision 3a; ~~256B.692, subdivision 1;~~ and
 45.21 256B.694; when contracting with MinnesotaCare participating entities;

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

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

APPENDIX
Article locations in HF3706-0

ARTICLE 1 COUNTY-BASED PURCHASING..... Page.Ln 1.17
ARTICLE 2 CONFORMING CHANGES..... Page.Ln 10.16

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.

APPENDIX
Repealed Minnesota Statutes: HF3706-0

(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.

APPENDIX
Repealed Minnesota Statutes: HF3706-0

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.