SENATE
STATE OF MINNESOTA
EIGHTY-SEVENTH LEGISLATURE

S.F. No. 866

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03/17/2011	540	Introduction and first reading Referred to Health and Human Services

A bill for an act

relating to health care; modifying county roles and rights related to state health care program purchasing; authorizing county-based purchasing arrangements; establishing a process to reduce administrative reporting; amending Minnesota Statutes 2010, sections 256B.0755, by adding a subdivision; 256B.69, subdivision 3a; 256B.692, subdivisions 2, 5, 7; 256B.694.

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

ARTICLE 1

LOCAL AND COUNTY ROLES IN STATE HEALTH CARE PROGRAM PURCHASING

Section 1. Minnesota Statutes 2010, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. **County authority.** (a) The commissioner, when implementing or administering the medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county, including proposals for demonstration projects established under section 256B.0755. County boards must be given reasonable opportunity to ~~make recommendations regarding~~ assist in the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make ~~recommendations~~ determinations regarding the approval

of local networks and their operations to ensure adequate local availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance funds. The county board ~~may recommend~~ shall decide a maximum number of participating health plans including county-based purchasing plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans, managed care plans, or demonstration projects established under section 256B.0755. The county board or a single entity representing a group of county boards and the commissioner shall mutually select one or more qualified health plans or county-based purchasing plans for participation at the time of initial implementation of the prepaid medical assistance program or a demonstration project established under section 256B.0755 in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those recommendations into the contract negotiation process.

(b) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals and health care delivery and access goals to meet the health needs of medical assistance enrollees. These requirements must be reasonably related to the performance of health plan managed care or delivery system demonstration project functions and within the scope of the medical assistance benefit set. ~~If the county board and the commissioner mutually agree to such requirements, the department~~ The commissioner shall include such requirements in all ~~health plan~~ contracts governing the prepaid medical assistance program in that county at initial implementation of the program or demonstration project in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract ~~provisions related to local public health goals~~.

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

contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(d) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans or demonstration projects under section 256B.0755 in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes ~~after taking into account~~ by approving the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one person selected jointly by the designee of the commissioner of human services and the designee of the Association of Minnesota Counties. Within a reasonable period of time before the hearing, the panelists must be provided all documents and information relevant to the mediation. The parties to the mediation must be given 30 days' notice of a hearing before the mediation panel.

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

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

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

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

(i) This section also applies to other Minnesota health care programs administered by the commissioner including, but not limited to, the MinnesotaCare program.

Sec. 2. Minnesota Statutes 2010, section 256B.692, subdivision 2, is amended to read:

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, effective January 1, 2010, 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. Notwithstanding this paragraph and paragraph (b), a county-based purchasing plan may satisfy its fiscal

solvency requirements by obtaining written financial guarantees from participating counties in amounts equivalent to the minimum amounts that would otherwise apply. A county-based purchasing plan must also assure the commissioner of health that the requirements of sections 62J.041; 62J.48; 62J.71 to 62J.73; 62M.01 to 62M.16; all applicable provisions of chapter 62Q, including sections 62Q.075; 62Q.1055; 62Q.106; 62Q.12; 62Q.135; 62Q.14; 62Q.145; 62Q.19; 62Q.23, paragraph (c); 62Q.43; 62Q.47; 62Q.50; 62Q.52 to 62Q.56; 62Q.58; 62Q.68 to 62Q.72; and 72A.201 will be met.

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

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

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

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

(2) an annual fee of $21,500, to be paid by June 15 of each calendar year, beginning in calendar year 2009; and

(3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents, based on the number of enrollees as of December 31, 2008.

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

Sec. 3. Minnesota Statutes 2010, section 256B.692, subdivision 5, is amended to read:

Subd. 5. **County proposals.** (a) On or before September 1, 1997, 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 on or before July 1, 1997. 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 on or before July 1, 1998, that demonstrates the ability to meet all the requirements of this section, including beginning enrollment on January 1, 1999, unless a delay has been granted under section 256B.69, subdivision 3a, paragraph (g).

(c) After January 1, 1999, 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 that meets the requirements of this section 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.

(d) The commissioner is not required to terminate contracts for the prepaid medical assistance program that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance program.

Sec. 4. Minnesota Statutes 2010, section 256B.692, subdivision 7, is amended to read:

Subd. 7. **Dispute resolution.** In the event the commissioner rejects a proposal under subdivision 6, the county board may request the ~~recommendation~~ decision of a three-person mediation panel. The commissioner shall resolve all disputes ~~after taking into account~~ by following the ~~recommendations~~ decision 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.

Sec. 5. Minnesota Statutes 2010, section 256B.694, is amended to read:

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

(a) Notwithstanding section 256B.692, subdivision 6, clause (1), paragraph (c), the commissioner of human services shall approve a county-based purchasing health plan proposal, submitted on behalf of Cass, Crow Wing, Morrison, Todd, and Wadena

Counties, that requires county-based purchasing on a single-plan basis contract if the implementation of the single-plan purchasing proposal does not limit an enrollee's provider choice or access to services and all other requirements applicable to health plan purchasing are satisfied. The commissioner shall continue to use single-health plan, county-based purchasing arrangements for medical assistance and general assistance medical care programs and products for the counties that were in single-health plan, county-based purchasing arrangements on March 1, 2008. This paragraph does not require the commissioner to terminate an existing contract with a noncounty-based purchasing plan that had enrollment in a medical assistance program or product in these counties on March 1, 2008. This paragraph expires on December 31, 2010, or the effective date of a new contract for medical assistance and general assistance medical care managed care programs entered into at the conclusion of the commissioner's next scheduled reprocurement process for the county-based purchasing entities covered by this paragraph, whichever is later.

(b) At the request of a county or group of counties, the commissioner shall ~~consider, and may~~ approve~~,~~ contracting on a single-health plan basis with ~~other~~ county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons ~~with a disability who voluntarily enroll,~~ enrolled in Minnesota health care programs in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in section 256B.69, subdivision 23, are satisfied. Nothing in this paragraph supersedes or modifies the requirements in paragraph (a).

ARTICLE 2

RURAL HEALTH CARE DELIVERY DEMONSTRATION PROJECTS

Section 1. Minnesota Statutes 2010, section 256B.0755, is amended by adding a subdivision to read:

Subd. 8. **Rural demonstration projects.** For demonstration projects serving rural areas, the commissioner shall consult with rural hospitals, primary care providers, county boards, health plans, and other key stakeholders primarily domiciled in the service area regarding the development and approval of alternative rural health care delivery demonstration projects under this section. In addition to organizations eligible to establish a demonstration project under subdivision 1, a rural demonstration project may be established by a county public health or social services agency or a county-based purchasing plan. In a rural area where multiple, competing provider-based demonstration

projects are not possible, the commissioner shall not approve more than one demonstration project to serve the primary geographic area and shall follow the applicable procedures and requirements in section 256B.692 regarding participation of county boards in reviewing and approving demonstration project proposals.

ARTICLE 3

REDUCTION OF REDUNDANT, UNNECESSARY, AND OBSOLETE STATE-MANDATED ADMINISTRATIVE REPORTS

Section 1. **REDUCTION OF STATE-MANDATED ADMINISTRATIVE REPORTS.**

(a) The commissioner of management and budget shall convene a report reduction working group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, obsolete, and low-priority state-mandated administrative reports required of health plans and county-based purchasing plans that serve persons enrolled in Minnesota health care programs. The commissioner of management and budget and the report reduction working group shall develop a plan to oversee the report reduction activities of the individual state agencies and coordinate the activities of multiple state agencies to consolidate reports or eliminate redundant reports required by more than one state agency on the same or a similar topic.

(b) The commissioners of health, human services, and commerce shall reduce, eliminate, or consolidate state-mandated reports according to the plan developed by the commissioner of management and budget through the report reduction working group. In addition to other report reduction actions the commissioners or the working group may undertake, the commissioners shall:

(1) collect encounter data, including provider payment data if collected, in a consolidated report provided to a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(2) collect only one provider network report annually through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data;

(3) collect only one standard financial report through a single state agency, with the data collected by that state agency to be shared with other state agencies who need the data. Data collected must be of a nature and in a format to allow comparison of the cost-effectiveness of fee-for-service payment systems and prepaid programs administered by health plans and county-based purchasing plans;

(4) consolidate and simplify reports and documentation requirements relating to member communications and marketing materials, and establish a single review process for all programs, products, and agencies in order to ensure uniform and consistent regulation of health plan contracts;

(5) consolidate state regulation and oversight of health plans and county-based purchasing plans so that activities of multiple agencies are administered through an efficient and uniform multiagency process of oversight and audits, with consistent standards, measures, and definitions for state oversight of quality, utilization management, care management, delegation accountability, access to care, appeals and grievances, and financial management;

(6) establish uniform requirements and procedures for denial, termination, or reduction of services, and member appeals and grievances, and align state requirements and procedures with federal requirements and procedures;

(7) reform the state's performance improvement projects, requirements, and procedures to be more flexible and efficient, and to place greater focus on measuring improvement of outcomes and less on mandating detailed or prescriptive requirements for specific performance improvement projects or activities;

(8) new reporting requirements or ad hoc report requests shall be established by a state agency only:

(i) if required by a federal agency;

(ii) if needed for a state regulatory audit or corrective action plan; or

(iii) after the completion of a review and analysis, and the development of recommendations by the commissioner of management and budget, in consultation with the report reduction working group, regarding the necessity, importance, and administrative cost of the new report, and after completing a review to determine whether the information sought can be obtained through another available state or federal report. The results of the review, analysis, and recommendations of the commissioner of management and budget must be provided to health plans and county-based purchasing plans for review and comment at least 60 days before a new report or requirement is established; and

(9) to the extent possible, all state agencies shall use the procedures, reports, and audits of the Centers for Medicare and Medicaid Services instead of requiring an additional state-mandated report on the same or a similar topic.

(c) By January 15, 2012, the commissioner of management and budget shall provide a report on the activities and results of the report reduction project to the chairs and ranking minority members of the legislative committees of the house of representatives

and senate with jurisdiction over health plans or county-based purchasing payments, regulations, and performance. The report must include:

(1) a timetable for report reduction actions already taken or planned by the commissioners or the report reduction working group;

(2) the specific reports that have been or will be eliminated or consolidated;

(3) the amount of money that will be saved through reductions in administrative costs of health plans and county-based purchasing plans as a result of the report reduction project; and

(4) proposed legislation for changes to laws or rules that are needed to allow state agencies to further reduce, consolidate, or eliminate reports when the changes cannot be made administratively.

APPENDIX
Article locations in 11-2572