4-1800-5344-1

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of the Proposed Rules of the Department of Human Services Relating to Prepaid Medical Assistance Programs; Parts 9500.1450 to 9500.1464.

REPORT OF THE ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Administrative Law Judge Peter C. Erickson on Wednesday, April 24, 1991 at 9:00 a.m. in Room D, Fifth Floor, Veterans Service Building, 20 West 12th Street, in the City of St. Paul, Minnesota.

This Report is part of a rulemaking proceeding pursuant to Minn. Stat. §§ 14.131 to 14.20 to determine whether the Department of Human Services has fulfilled all relevant substantive and procedural requirements of law, to determine whether the proposed rule amendments are needed and reasonable, to determine whether the Department has statutory authority to adopt the rule amendments, and to determine whether or not the amendments, if modified, are substantially different from those originally proposed.

Members of the agency panel appearing at the hearing included: Patricia MacTaggart, Assistant Director, Health Care Management; Ann Rogers, Prepayment Advisor, Health Care Management; Mary Jo Cairns, Prepayment Representative, Health Care Management; Jim Schmidt, Rulemaker, Rule and Bulletins Division; and Kim Buechel Mesun, Special Assistant Attorney General, representing the Department.

Approximately fifty persons attended the hearing and 48 signed the registration sheet. Thirty-nine written comments were submitted by members of the public. The Department submitted twenty written exhibits.

The Commissioner of the Minnesota Department of Human Services must wait at least five working days before taking any final action on the rules; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 14.15, subd. 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings of this Report, he will advise the Commissioner of actions which will correct the defects and the Commissioner may not adopt the rule until the Chief Administrative Law Judge determines that the defects have been corrected. However, in those instances where the Chief Administrative Law Judge

identifies defects which relate to the issues of need or reasonableness, the Commissioner may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the Commissioner does not elect to adopt the suggested actions, s/he must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the Commissioner elects to adopt the suggested actions of the Chief Administrative Law Judge and makes no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, then the Commissioner may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the Commissioner makes changes in the rule other than those suggested by the Administrative Law Judge and the Chief Administrative Law Judge, then s/he shall submit the rule, with the complete record, to the Chief Administrative Law Judge for a review of the changes before adopting it and submitting it to the Revisor of Statutes.

When the Commissioner files the rule with the Secretary of State, s/he shall give notice on the day of filing to all persons who requested that they be informed of the filing.

Based upon all the testimony, exhibits and written comments, the Administrative Law Judge makes the following:

FINDINGS OF FACT

1. On February 15, 1991, the Department filed the following documents with the Chief Administrative Law Judge pursuant to Minn. Rule 1400.0300, subp. 1a.:

(a) A Statement of the number of persons expected to attend the hearing and the length of the Agency presentation together with a Statement concerning additional notice given by the Department. (Ex. A).
(b) A certified copy of the proposed rule amendments. (Ex. B).
(c) The Order for Hearing. (Ex. C).
(d) A proposed Notice of Hearing. (Ex. D).
(e) A fiscal note. (Ex. E).
(f) A Statement of Need and Reasonableness. (Ex. F).

2. On March 11, 1991, the Notice of Hearing and the proposed rule amendments were published in the State Register at 15 State Register 2024. (Ex. N).

3. On March 11, 1991, the Department filed the following documents with the Administrative Law Judge:

(a) The Notice of Hearing as mailed. (Ex. H).
(b) The Agency's certificate concerning its rulemaking mailing list. (Ex. I).
(c) The Affidavit of Mailing. (Ex. J).
(d) An Affidavit of Additional Mailing. (Ex. K).
(e) A copy of the Notice of Solicitation of Outside Opinion. (Ex. L). No responses were received to this notice.

(f) A Statement of the Agency personnel who would represent the Agency at the hearing. (Ex. M).
(g) A copy of the proposed rule amendments as printed in the State Register. (Ex. N).
(h) A copy of the letter to the Legislative Commission to Review Administrative Rules submitting a copy of the Statement of Need and Reasonableness to them. (Ex. O).

The documents were available for inspection and copying at the Office of Administrative Hearings from the date of filing.

3. The period for submission of written comments and statements from the public remained open through Tuesday, May 14, 1991 at 4:30 p.m., twenty (20) calendar days after the hearing. The record remained open for an additional three (3) working days through May 17, 1991 for responses to earlier submissions.

Nature of the Proposed Rule

4. The proposed amendments amend a set of rules governing the Medical Assistance Prepaid Demonstration Project which is now to be known as the Prepaid Medical Assistance Program. The Project was established to determine whether contracting with prepaid health plans would allow the state and participating counties to contain medical costs while providing quality health care services to Medical Assistance consumers. The Project has operated in Dakota, Hennepin and Itasca Counties. As of December 1, 1990 there were approximately 45,314 individuals enrolled in the Demonstration Project in the three counties. The Project was one of five original Demonstration Projects authorized by the Federal Health Care Financing Administration to test cost effective alternatives for payment and delivery of Medicaid services. The Department asserts that these amendments are necessary to comply with legislative changes in the program, to correct rule cites no longer accurate, and to provide more efficient administration of the program.

Statutory Authority

5. The Department states that statutory authority for these rule amendments is contained in Minn. Stat. §§ 256B.031, 256B.69 (which authorizes the prepaid MA program), 256B.045, and waivers approved by the Federal Health Care Financing Administration. Minn. Stat. § 256B.69, subd. 16, specifically extends the rules in question. Minn. Stat. § 256B.69, subd. 17, provides that "The Commissioner may continue the provisions of this section after June 30, 1990, in any or all of the participating counties if necessary federal authority is granted. The Commissioner may adopt permanent rules to continue prepaid medical assistance in these areas." The Department has demonstrated its general statutory authority to adopt the proposed rule amendments.

Rule Development Procedures

6. The Department sought to achieve public input through a Notice to Solicit Outside Opinion published February 21, 1989. Additionally, it established a Rule 62 Prepaid Medical Advisory Program Advisory Committee with

representatives from the three counties involved, health care providers, Legal Aid, and consumer groups. The Advisory Committee met three times.

Small Business Considerations in Rulemaking

7. The Department states that after examining Minn. Stat. § 14.115 it determined that the amendments are exempt from these requirements. Under Minn. Stat. § 14.115, subd. 7(3), the small business consideration requirement does not apply to service businesses regulated by government bodies, for standards and costs, such as nursing homes, long term care facilities, hospitals, providers of medical care, daycare centers, group homes and residential care facilities, but not including businesses regulated under Chapter 216B or 237. The Department has complied with Minn. Stat. § 14.115.

Fiscal Note

8. Minn. Stat. § 14.11, subd. 1, requires agencies proposing rules requiring the expenditure of public funds in excess of $100,000 per year by local public bodies to publish an estimate of the total cost to local public bodies for a two-year period. The Department prepared a fiscal note in connection with this rule proceeding. (Ex. E). It estimates that in fiscal year 1992 the three counties participating in the Prepaid Medical Assistance Program will save $299,000 over what would be expended in the Medical Assistance Fee for Service Program. In fiscal year 1993 the savings are estimated at $303,000. The fiscal note estimates that the savings to the State of Minnesota in each fiscal year is approximately $2.7 million. The Department states that the amendments to the proposed rule will not increase or decrease local costs to the three counties involved.

Impact on Agricultural Land

9. Minn. Stat. § 14.11, subd. 2 requires agencies proposing rules that have a "direct and substantial adverse impact on agricultural land in this state" to comply with additional statutory requirements. These rules have no impact on agricultural land and, therefore, the additional statutory provisions do not apply.

Substantive Provisions

10. The proposed rule amendments which received public comment or otherwise need to be examined due to, for example, problems of legality, are discussed below. Any rule or rule amendment not mentioned is found to be needed and reasonable and in compliance with all substantive requirements of law or rule. Any modification of an amendment not specifically discussed is found not to be a substantial change.

9500.1450 - Introduction

11. 9500.1450, subp. 3 provides that the Commissioner may expand the prepaid medical assistance program after giving timely notice. Several

commentors asked that the notice period be specified and the suggestions ranged from six months to two years. The Department accepted the suggestions and modified the subpart by requiring "at least 180 days" notice. Ex. P, p. 2. Other comments indicated that the subpart should indicate that the program not be expanded or expanded only after more research. The Department replied that the Legislature clearly wanted the program expanded based on the results since 1985, and provided the Commissioner with authority to do so. The Department also proposed another modification by replacing "the Commissioner may expand" with "the Commissioner shall expand" in order to minimize discretion. So modified, the subpart is needed and reasonable. The changes are not substantial. The Department might consider, for the purposes of clarity and tracking the statute, replacing the first two sentences with the following:

> PMAP shall be operated in the counties of Dakota, Hennepin, and Itasca, and other geographic areas designated by the Commissioner.

This language would avoid the mandatory connotation of the Department's proposed modification.

9500.1451 - Definitions

12. Two providers asked that the definition of "appeal" at 9500.1451, subp. 2(a) as well as the later definition of "complaint" be amended to permit appeals by providers. The Department declined to make this change in light of statutory language permitting "recipients" to file a complaint or appeal. It noted that a PMAP consumer may designate an authorized representative to act on his or her behalf and that this may be a provider. Minn. Stat. § 256.045, subd. 3, does not permit a vendor of medical care to request an appeal. Minn. Stat. § 256B.69, subd. 6(b), sets forth the standards for claims settlement. The definitions are needed and reasonable as proposed.

13. 9500.1451, subp. 4(a) defines "case management". The Minneapolis Children's Medical Center suggested changing the term defined to "health services coordination" to avoid the term "case management" which has a different meaning in the mental health field. The Department declined to make the change indicating that case management is a term common in social service programs but which has a number of different meanings. Since it is used throughout the rules, the Department proposes to define it. Ex. Q, p. 2. The Legal Aid Society of Minneapolis argued that the proposed definition was more narrow than that contained at 9500.1460, subp. 15. It argued that definitions should clearly make the health plan responsible for coordinating the needs assessment, provision, revision and monitoring of health services to an enrollee. The Department agreed that "the health plan" should be specified as responsible for coordinating the provision of health services. So modified, the definition is needed and reasonable. The change is not substantial.

14. 9500.1451, subp. 14, defines "medical assistance population or MA population." One commentor asked that "AFDC related" be defined and another suggested that "medically needy" be eliminated. Rather than attempt further definition, the Department proposed to modify the definition to simply indicate that it means "a category of eligibility for the medical assistance program, the eligibility standards for which are set out in Minn. Stat.

§ 256B.055 and parts 9505.0010 to 9505.0150." So modified, the proposed definition is needed and reasonable. It is not a substantial change.

15. 9500.1451, subp. 14(a), defines "multiple health plan model". Three commentors stated that three or more health plans should be indicated as available and another commentor favored four health plans. The Department declined to accept the recommendation and noted that in the event that one of two health plans withdraws from the program in a county where the multiple health plan model exists, the state is mandated to terminate PMAP. Ex. P, p. 5. The definition is needed and reasonable as proposed.

16. "Ombudsman" is defined at 9500.1451, subp. 14(b). Two commentors asked that minimum qualifications be set for the ombudsman in the definition. The Department stated that it did not have the authority to establish qualifications since they are established by the Department of Employee Relations and collective bargaining agreements. Ex. B, p. 6. The definition is needed and reasonable as proposed.

17. Several commentors, including the Legal Aid Society of Minneapolis, asked that "participating provider" be defined since it is used in the rules. The Department agreed to do so and defined "participating provider" as "a provider who is employed by or under contract with the health plan to provide health services." "Non-participating provider" was defined in a parallel fashion. Ex. P, p. 3. the new definitions are needed and reasonable and do not constitute a substantial change in the rules.

18. 9500.1451, subp. 14(i), defines "primary care provider health plan model". One commentor suggested that other providers such as a clinic, a nurse, a midwife or a nurse practitioner be added to the list of designated providers. The Department noted, however, that primary care providers are the physician and dentist and the services of the other providers mentioned must be provided under the direction of the primary care provider. Ex. P, p. 6. The definition is needed and reasonable as proposed.

19. 9500.1451, subp. 16, defines "rate cell". One commentor suggested the addition of the characteristics of pregnancy rate and pre-term birth rate. The Department noted, however, that it is not clear how data on pregnancy rates and pre-term birth rates relates to demographic characteristics. Ex. Q, p. 2. Another commentor observed that with respect to the mental health area, there is no actuarially-equivalent population. The Department noted that federal law requires the rate cell to be based on demographic characteristics. The Department did suggest modification to limit the Commissioner's discretion by striking the "may include, but are not limited to," language. So modified, the proposed definition is needed and reasonable, does not constitute a substantial change, and meets legal requirements.

20. 9500.1451, subp. 16(a), defines "rate cell year". Hennepin County suggested a change to allow health plans to receive higher capitation rates if enrollees become Medicare eligible prior to their annual eligibility review. The Department stated that in order to implement the recommendation it would require either a costly manual process or a costly system redesign to address rate cell changes more often than on an annual basis. Ex. P, p. 7. The definition is needed and reasonable as proposed.

21. 9500.1451, subp. 17(a), defines "spend-down". Hennepin County recommended that spend down include eligibility with a six-month spend down or a monthly spend down which is determined month by month during a six-month eligibility period. However, the Department noted that all spend-down recipients are exempt from participation in PMAP. Ex. P, p. 7. The definition is needed and reasonable as proposed.

9500.1452 - Eligibility to Enroll in a Health Plan

22. 9500.1452, subp. 2, sets out medical assistance categories which are ineligible for PMAP. Subp. 2D makes ineligible a person who is receiving benefits under the Refugee Assistance Program. Two commentors, including Ramsey County, indicated that this category should include persons who have received such benefits in a prior period (thirty-two months or two calendar years). Ramsey County noted that changes in the program over the last four years reflect federal fiscal constraints rather than specialized needs in those who are refugees. The Department declined to accept the suggestion because the Federal Refugee Program is 100% federally funded and when the federal government determines that the refugee is no longer eligible, the state must comply. The Department also indicated that when eligibility and funding are terminated, there is no systematic way to identify individuals through a two-year period. Ex. P, p. 7. The definition is needed and reasonable as proposed.

23. 9500.1452, subp. 2F, excludes a person who is determined eligible for medical assistance due to blindness or disability unless the recipient is 65 years of age or older. Several commentors argued that disabled persons over 65 should also be excluded or at least allowed a choice as to whether to join the program. It was noted, for example, that a recipient of mental health services may have a relationship with a provider based upon trust which would be disrupted upon reaching age 65. The Department noted in its Statement of Need that Minn. Stat. § 256B.69, subd. 4, specifically exempts the disabled receiving MA unless they are 65 years of age or older. The Department states that the federal MA program does not include a category of disability for individuals aged 65 and over. Persons over 65 are under the aged category of eligibility for MA. Ex. Q, p. 6. Hennepin County asked that this item be modified to exclude clients who are disabled but have not been certified as disabled. The Department declined because federal MA rules do not allow a finding of disability until the state medical review team or the Social Security Administration determines the disability. The counties must inform clients of the exclusion to participation in PMAP due to disability. Ex. P, p. 12. Subp. 2F is needed and reasonable as proposed.

24. 9500.1452, subp. 2G, excludes persons eligible for MA who currently have private health insurance coverage through an HMO. The Legal Aid Society of Minneapolis argued that someone eligible for but not yet in a private HMO should be ineligible for PMAP since federal law requires private HMO enrollment where cost effective of those eligible for it with MA paying the premiums. The Department argues that such an interpretation is too broad since an individual may have a long waiting period before they are actually eligible for insurance and during this period they should be required to enroll in a health plan. They can be disenrolled from PMAP once they are enrolled in a private plan. Ex. Q, p. 10. The item is needed and reasonable as proposed.

25. 9500.1452, subp. 2H, excludes persons residing in Itasca County, living near the border, and using a primary care provider located in a neighboring county. The Legal Aid Society of Minneapolis argued that this item should be expanded to include all persons who do not have reasonable access to services due to distance or other transportation barriers. It argued that it was unreasonable to make distinctions between provider inaccessibility in Itasca County and Hennepin County solely because Itasca County itself is the health plan. The Department stated that the difference between the counties is that in the Metropolitan counties, the health plans have agreed to provide services to enrollees throughout the entire county whereas the health plan in Itasca did not have the ability to provide services, including non-ambulatory transportation, throughout the entire county. Ex. Q, p. 11. The item is needed and reasonable as proposed.

26. 9500.1452, subp. 2J, excludes persons who are terminally ill and have a permanent relationship with a primary physician who is not part of the health plan. Several commentors argued that persons diagnosed with an HIV infection should be excluded. The Department agreed that an interruption in medical service and assignment to providers ill-equipped to deal with HIV could have a damaging and permanent effect on both the individual and on the state's effort to control the spread of the disease. The Department proposed adding an item L excluding persons with communicable diseases where the prognosis was terminal, the person's primary physician was not a provider in the health plan and the physician certifies the necessity of continuing the relationship. Ex. P, p. 9. The addition of the new item L is not a substantial change but is merely an expansion of item J. It is needed and reasonable based upon the record.

27. 9500.1452, subp. 2K, exempts persons who are in Title IV-E foster placement. Two commentors, including Hennepin County, suggested that the category be expanded to include all those in foster placement and not just those covered by Title IV-E since it would make placement difficult and because it is important to keep the foster children with the same health care providers as their foster family. The Department agreed to the suggestion to the extent that it suggests adding family foster homes to the optional exclusions set out in subp. 3.A. This means that non-Title IV-E foster placements may be excluded if approved by the Commissioner. The change is not a substantial one. Subp. 2.K. is needed and reasonable as proposed.

28. A large number of the comments in this rulemaking proceeding argued in favor of adding other exclusions from PMAP to subp. 2. Many mental health service providers argued in favor of exempting mental health services from PMAP. They stated that HMOs were providing inadequate care both in terms of quality and delivery of services. They pointed out that personal relationships were uniquely important in the provision of mental health services and argued that at least existing relationships ought to be exempt from participation in PMAP. The Department pointed out that the state statute requires PMAP to provide "all needed health services". Since mental health services are a needed health service under Minn. Stat. § 256B.0625, the Department asserts that it has no authority under federal law to exclude this service. The commentors provided strong examples of how persons in PMAP can have difficulty finding appropriate mental health services. This is a problem which both DHS and the Department of Health must address. However, the state and federal law appears to contemplate inclusion of mental health services

within PMAP. The Department should give strong consideration to the feasibility of "grandfathering in" existing theraputic relationships so that they are not disrupted by a transfer to PMAP.

29. Other commentors argued for exclusion of persons with chronic illnesses and persons who are developmentally delayed or mentally retarded. The Department believes that the "chronic illness" language is not workable since many illnesses are chronic. It noted that in regard to individuals with developmental delays or mental retardation, individuals determined eligible for medical assistance due to disability are excluded under subp. 2.F. Ex. P, p. 8. Other commentors argued for an exclusion for "adults who have been identified as seriously and persistently mentally ill". The Department also declined to make this change since it believes that case management functions for such recipients will prevent the disruption of their care. Ex. P, p. 8.

30. Legal Aid of Minneapolis argued for three additional exemptions, namely for persons eligible to utilize medical assistance to purchase benefits formally paid for by an employer, for persons who cannot communicate adequately with a provider, and for persons for whom changing providers would have a negative effect. Legal Aid argued that it was arbitrary to allow exclusion for those terminally ill (subp. 2.J.) while not extending the same privilege to those people who would be likely to have a serious and foreseeable negative effect by changing providers. Southern Minnesota Regional Legal Services (SMRLS) supported an exclusion for persons who are unable to receive adequate services due to a language barrier and also urged that it be expanded to include persons unable to receive adequate services due to other special conditions. It was pointed out that federal law requires that those in the program receive care equal to those MA recipients in a fee-for-service situation. The request concerning communication was supported by the affidavits of Russian immigrants which illustrated the problems they have had receiving health services in PMAP.

In its post-hearing comments, the Department argued that a catch-all exclusion or an exclusion concerning the "negative effect" in changing providers was simply too vague and would permit too much discretion in its application. It suggested that the complaint and appeal provision would provide an avenue to deal with special conditions. Ex. Q, p. 8, 10. It also noted that the federal provision permitting a person eligible to utilize MA to purchase benefits formerly paid for by an employer was a permissive federal provision not yet in state law. Ex. Q, p. 10. In regard to providing an exclusion for those who cannot communicate effectively with the provider because spoken English is not their primary form of communication, the Department asserts that reasonable solutions have been arrived at to meet this problem, including each health plan being required to have access to interpretation services, some health plans having staff who can provide interpreting services, and health plans listing their medical providers that serve non-English-speaking enrollees. It argues that the work of interpretation services, resettlement agencies, sponsors and family members in interpreting for recipients has proven effective in that there is no evidence that recipients in the prepaid program are not getting services. It points out that there is no provision in the MA fee for service program for translators. Ex. P, p. 11-12, Ex. Q, p. 10. The failure to include the exclusions discussed above cannot be said to be unreasonable in the legal sense. The Department has articulated its policy judgment and made a reasoned determination. Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238

(Minn. 1984). Neither can the failure to include the proposed modification be said to violate federal law given the Department's explanation. The affidavits in the record do indicate that problems exist which must be addressed and corrected, however, that does not render the rule itself, as proposed by the Department, unreasonable.

31. 9500.1452, subp. 3, sets out certain optional exclusions. Counties may exclude these categories if approved by the Commissioner. Several commentors noted that there were no criteria to guide the Commissioner's approval process and others urged that the items listed be flat exclusions rather than optional. Legal Aid of Minneapolis noted that Minn. Stat. § 256B.04 requires uniform administration of the system, which would be difficult without standards to determine when the Commissioner would approve or disapprove. Legal Aid also suggested adding the families of the children to subp. 3.B. and C. and also suggested that the counties be permitted to propose additional categories for exclusion. The Department stated that families should not be added to B. and C. since under the case management system the health plan was responsible for coordinating its services with that of other health care providers. The Department felt that Legal Aid's suggestion concerning additional categories for exclusion would involve "unbridled discretion". Ex. Q, p. 11. In regard to the lack of criteria to guide the Commissioner, the Department stated that the proposed language did not result in unbridled discretion since subp. 5 of the rule allows the MA recipient to enroll in the PMAP program at their option. Ex. P, p. 14.

Generally, a rule granting discretion must contain standards that control and guide the administrator and limit her discretion. Anderson v. Commissioner of Highways, 267 Minn. 308, 311-12, 126 N.W.2d 778, 780-81 (1964); Lee v. Delmont, 228 Minn. 101, 113, 36 N.W.2d 530, 538 (1949). Although a recipient may opt back into the PMAP if excluded by the county and Commissioner, the Commissioner's decision in this regard still has important consequences. The counties and the recipients are entitled to know what standards are to be employed in making this judgment, to lend predictability to the process and to avoid arbitrary decision-making. The lack of standards constitutes a defect and is a violation of a substantive provision of law. To correct this defect, the Department may either make the optional exclusions mandatory or adopt reasonable criteria based upon the considerations set out in the Statement of Need and Reasonableness.

32. Two commentors argued that language should be added to subp. 3.C. indicating that the exclusion lasted until the child protection case was closed. The Department accepted the suggestion and added the phrase "until termination of protected services under part 9560.0228, subp. 6." The change is not a substantial one and the subpart, together with the addition of the family foster home optional exclusion, is needed and reasonable as proposed.

33. 9500.1452, subp. 4, deals with exclusions during the phase-in period. Because legislation was pending at the time of the hearing to include Ramsey County in PMAP, the Department has proposed language to add to this subpart which would set up a phase-in period for counties beginning participation after June 30, 1991. It provides for a one-year phase-in period from the start of the enrollment period for each category of eligible PMAP consumer. The modification is not a substantial change. It merely acknowledges that it is physically impossible to convert all recipients on fee-for-service to the prepaid program immediately. It is needed and reasonable.

9500.1453 - Mandatory Participation; Free Choice of Health Plan

34. 9500.1453, subp. 2, sets out the process for selection of a health plan in multiple health plan model counties. Two commentors suggested that a notice to the consumer be in writing or "verbally". The Department declined to add that language since the statute does not authorize verbal notification and there is a face-to-face interview at the time of application for medical assistance. Ex. P, p. 15. Other commentors suggested a longer time period for a consumer to select a health plan. It was also suggested that the local agency be required to provide additional assistance to the consumer. The Department declined to make county assistance mandatory but did agree to extend the time for selection of a health plan to thirty days. It also proposed to delete ambiguous language concerning "the time limit established by the Commissioner" and instead proposed language which simply requires a local agency to assign a health plan at the end of a thirty-day period. It also deleted the permissive language concerning additional assistance to the consumer, presumably because nothing would prohibit this in any event. The proposed modifications are not substantial. So modified, subpart 2 is needed and reasonable. Comparable changes were made in subpart 3.

35. 9500.1453, subp. 7, deals with changing health plans. Legal Aid questions the necessity of having a Human Services referee make that decision and also thought that some indication of what constituted "cause" should be contained in this subpart. The Department proposed to delete subpart 7 and replace it with an enrollee option to change health plans once anytime during the initial year and thereafter during open enrollment. These modifications were placed into subpart 5 and 6. Ex. P, p. 17. The change eliminates the needs for enrollees to demonstrate good cause. However, SMRLS points out that problems may develop during the second or later years warranting a change in health plans. It appears that the deletion of subpart 7 would result in enrollees being unable to disenroll even though excessive travel time is required, they're receiving inadequate health care services or they have other good cause to disenroll. SMRLS supported the changes to subparts 5 and 6, but argued that subpart 7 should remain. The change is not a substantial one. It might be argued that permitting a change during the first year or annually at open enrollment is almost as flexible as the procedure contained in subpart 7. It may, however, require a consumer to wait several months to make a change. The Department should consider whether this provides adequate flexibility when the conditions set out in subparts 7A and B are present.

36. A commentor questioned whether the state was given unbridled discretion in 9500.1453, subp. 9, by use of the phrase "may authorize". The Department proposed that the county simply be required to make the change with notification to the Commissioner but with no approval required. Ex. P, p. 18. The Department also proposed that a similar notification be required in subpart 8. The changes are not substantial and result in language which does not violate a substantive provision of law.

37. 9500.1453, subp. 10, states that mandatory participation in PMAP does not constitute a restriction of free choice of provider. Legal Aid argued that this subpart was confusing since limitation on choice does occur and is one reason why a waiver from the federal government is necessary. The Department agreed to delete the subpart. The change is not substantial since

the matter is dealt with in federal waivers and state statutes. The deletion is needed and reasonable.

9500.1455 - Third Party Liability

38. This rule requires the health plan to coordinate benefits for its enrollees who have other coverage, including paying applicable co-payments or deductibles. Two commentors asked that the rule require these payments to be made within thirty days. The Department did not believe that this was an appropiate change but did propose a modification to cross-reference the statutory provision dealing with claims settlement. The modification is not substantial but is a useful cross-reference. So modified, the rule is needed and reasonable.

9500.1457 - Services Covered by PMAP

39. Several commentors suggested that services such as speech and language services, audiology and rehabilitative services be specifically added to the first paragraph of subpart 1 of 9500.1457. The Department noted that PMAP is only required to provide the same services authorized under the Medical Assistance statute and rules and that that is accomplished by citing to them. Hennepin County suggested that case management services for children with severe emotional disturbances be added to subpart 1.A. The Department declined to do so since it is not yet an MA covered service but will comply when it is covered by MA. Legal Aid suggested that a provision be added to subpart 1 requiring a health plan to inform enrollees of the existence of non-covered services and how to access them. The Department believes that the health plan cannot be required to inform enrollees of services which it does not provide and noted that the local agency provides information to MA applicants at the time of application regarding MA covered services. Ex. Q, p. 13. Subpart 1 is needed and reasonable as proposed.

40. 9500.1457, subp. 3, exempts health plans for prior authorization. One commentor suggested adding language which stated that authorizations for occupational therapy shall be based upon medical necessity for restoration or maintenance of function. The Department declined to add this language because all MA services are based on medical necessity. MA coverage for occupational services includes restorative and specialized maintenance therapy. The subpart is needed and reasonable as proposed.

9500.1458 - Data Privacy

41. Legal Aid argued that providers who contract with the health plan to provide services should be included in the data privacy provision. The Department declined to add this suggestion, stating that the contract is with the health plan and therefore, the Department holds the health plan liable for all provisions relating to data privacy. The Department argues it is more appropriate for the health plan to be ultimately responsible for data practices requirements and that information only be shared with subcontractors which is necessary to administer a client's MA benefits. Ex. Q, p. 13. The rule is needed and reasonable as proposed.

9500.1459 - Capitation Policies

42. This rule is proposed to be amended to provide that the capitation rates be reviewed by an independent actuary and that the rates established must be less than the average per capita fee for service medical assistance costs for an acturarial equivalent population. Hennepin County expressed concern about how an "actuarial equivalent population" will be defined when the fee for service base no longer exists. The Department indicated that it was considering two options, namely, the use of historical fee for service data that spans a number of years to develop a ratio, and pursuing contractual rates of reimbursement with health plans based on current medical assistance rates and projected utilization targets. The Department commented that the date range used for the formulation of capitation rates is sufficiently far back so as not to pose a heightened problem until the development of the state fiscal year 1994 rates. Ex. P, p. 21. Another commentor suggested that the original rule be retained. The Department noted, however, that the language had to be changed because for certain counties it requires the Department to use 1982 or 1983 data that has been substantially altered by time. Ex. Q, p. 3. The Legal Aid Society of Minneapolis suggested several changes in the proposed language so that it would more closely track the statute and to provide that the data involved would be made public. It also suggested language which would specifically state that the rates reflect the risk base composed of those subpopulations receiving more intensive services from subcontractors of the health plan or of the health plan itself. The Department adopted the suggestion concerning tracking the statute and proposes to modify the language by simply referencing § 256B.69, and dropping the "must be reviewed by an independent actuary . . ." language. It also proposes language which makes the rates and rate methodology, as well as the contracts, public. It did decline Legal Aid's proposed language concerning setting capitation rates based on subpopulations since the rates are not set on the basis of a medical diagnosis. Ex. Q, p. 14. The modifications are not substantial. So modified, the rule has been shown to be needed and reasonable.

9500.1460 - Additional Requirements

43. 9500.1460, subp. 3, states what services must be provided by a health plan. Several commentors urged that phrases "or ensure" and "access to" be removed to conform to the statute. The Department agreed to do so and additionally, to add clarity, to change the word "referenced" to "excluded". The changes are not substantial. So modified, the proposed rule is needed and reasonable.

44. 9500.1460, subp. 5, deals with plan organization. Three commentors argued that plans should be limited to not for profit organizations. The Department pointed out, however, that Minn. Stat. § 256B.69, subd. 5, explicitly permits payment to providers that are not licensed HMOs under Minnesota law. Ex. P, p. 22. The subpart, the substance of which is not proposed for amendment, is needed and reasonable as proposed.

45. 9500.1460, subp. 6, requires health plans to provide a current list of providers and permits the Commissioner to review and terminate a subcontract. One commentor suggested language to require that a provider under contract with a long-term care facility to provide the health needs of

its residents shall provide the health service needs of any health plan enrollee. The Department noted that health plans are required to provide services to their enrollees but that the manner and terms of how those services are provided must be determined by the health plans. Ex. P, p. 22. One commentor pointed out the discretion given to the Commissioner by the phrase "may require". The Department did agree to modify this language by changing "may" to "shall" and deleting "when the Commissioner determines that" from the language of the rule. In order to further limit discretion, the Department proposes to delete language concerning "quality assurance standards" in subp. 6.C. Finally, the Department proposes deletion of the language which reads, "The subcontract may be reviewed by the Commissioner upon request." Ex. P, p. 24. Legal Aid argued that the subcontracts should be required to be provided to the Commissioner under the rule and should be made public. It was suggested that it was important for the Commisisoner to review contracts to see if they shifted financial risk to the provider and that the rule should contain standards as to financial risk.

The Department responded that the Department of Health currently requires submission of subcontracts as part of their licensing and monitoring function under Chapter 62.D. of the statutes. The Department believes that any further review by DHS would be a duplication and suggests that state law presently classifies subcontracts as confidential information rather than public. Ex. P, p. 23. In reply to the Department's comments, SMRLS stated that it believed that typical subcontract information submitted to the Department of Health by HMOs does not include dollar amounts, percentages or any other information from which the Department could determine the amount of financial risk which has been transferred to the subcontracting provider from the HMO. It argued that if excessive risk is shifted without adequate payment to the subcontractor, such an arrangement could, in essence, be mandating that inadequate care be provided to MA recipients. It was also suggested that Chapter 62.D. of the statutes which makes contract information confidential, applies only to a few of the subcontractors and only at the option of the HMO. SMLRS suggested also that rather than deleting language permitting the Commissioner to review subcontracts upon request that the rule should indicate that a subcontract shall be provided to the state upon request. The question of the appropriateness of review of some subcontracts to ensure that financial risk is not being transferred to participating providers and the question of who is to do this review is a question of policy. The proposed rule subpart is neither unreasonable or illegal because it lacks the language suggested by Legal Aid. The Department may wish to review the question based on the later information supplied by Legal Aid. The Department should also consider whether or not language to the effect that subcontracts shall be provided to the Commissioner upon request would better accomplish the rule purpose.

46. 9500.1460, subp. 7, deals with enrollment capacity. A commentor pointed out the discretion in the rule which provides that the Commisisoner "may limit" the number of enrollees. The Department proposed to modify the language by eliminating the discretionary portion and simply providing that the Commissioner "shall limit the number of enrollees in the health plan upon the issuance of a contract termination notice under subpart 12." So modified, the proposed subpart is needed and reasonable and is not a violation of a substantive provision of law.

47. 9500.1460, subp. 8, deals with financial capacity. The Legal Aid Society of Minneapolis argued that certain provisions proposed for elimination

from the rules, namely 9500.1459, subps. 2, 3 and 4, dealing with aggregate risk sharing and individual stop loss coverage should be retained in subp. 8. It suggested that the language in the existing subp. 8 which requires a health plan to "demonstrate its financial risk capacity" is insufficient. The Department noted that the aggregate risk sharing concept was required to be phased out in the third year of PMAP under federal waivers. It also stated that the Department offered individual stop loss coverage for in-patient hospitalization as part of a contracting process with individual health plans. It noted that the stop loss provision referenced by Legal Aid deals with the health plan -- subcontractor relationship and not the relationship between the state and the health plan. Ex. Q, p. 15-16. The subpart is needed and reasonable as proposed.

48. 9500.1460, subp. 11.A., deals with liability for payment for authorized and unauthorized services. Some providers asked that "non-participating" and "participating" be defined, which the Department has done. Other providers wanted a maximum time period for payment by the health plan put in the rule. They also asked that the rules specify that payment to a non-participating provider be at least at the MA rate. Medica asked that the rule state that prior written notice be satisfied if the HMO supplies the enrollee with a participating provider directory and an identification card. SMRLS argued that this would not be a substitute for the participating provider giving the enrollee a written notice that the service by a non-participating provider will not be covered. Based upon comments that the subparts were unclear and permitted a participating provider to authorize a service with a non-participating provider without liability to the participating provider or the health plan, the Department proposes to simplify the language. As modified, subpart 11 would simply indicate that a health plan is not liable for payment for unauthorized health services rendered by a non-participating provider except for emergency health services or unless otherwise specified in contract. The Department proposes to drop the paragraph containing subpart 11 A-C. Subpart 11A will then provide that when a health plan or participating provider authorizes services for out-of-plan care, the plan shall reimburse the non-participating provider. The modification makes it clear that if a participating provider authorizes a service, the health plan must pay for it. The modification does meet some of the objections. It is not a substantial change. So modified, the subparts are needed and reasonable. The Legal Aid Society of Minneapolis submitted a comment during the 3-day period which stated that DHS' definition of "participating provider" presented a problem because it did not include persons or organizations the contractee would subcontract with. Legal Aid pointed out that the responsibility for providing notice and appeal rights could belong to a non-participating provider under the proposed definitions. It urged that it be made clear what the health plan can or cannot delegate. The Department should review the proposed definitions to ensure that it is clear to enrollees and providers alike where the responsibility lies for providing notice.

49. 9500.1460, subp. 14, deals with required educational materials. Two commentors suggested that the last paragraph provide for enrollees who are unable to read. The Department noted that the rule complied with Minn. Stat. § 256.016 which requires the use of plain language in written materials and establishes minimum reading standards. Ex. P, p. 27. The subpart is needed and reasonable as proposed.

50. 9500.1460, subp. 15, requires a case management system. Hazelden asked that the reference to individual "medical needs" be changed to "health care needs". The Department declined to adopt the suggestion because health plans are required to provide services that are medically necessary and the suggested language could be construed to mean social services or other non-medical services which are not covered under MA requirements. Ex. Q, p. 9. The Legal Aid Society of Minneapolis and others objected to the phrase "when medically necessary" in the proposed rule on the grounds that it provided too much discretion and did not implement the statute which requires the provision of case management to every enrollee in PMAP. The Department agreed to delete the phrase and agreed that this would better reflect statutory intent. Ex. P, pp. 27-28. The change is not substantial. Legal Aid further objected to the subpart as proposed because it does not set out specific requirements for the case management system. Legal Aid argued that the rule should require an individual needs assessment, an individual plan of care developed and implemented with participation by the enrollee, and evaluation of the plan on at least a six-month basis. The Department argued, however, that the proposed language was consistent with Minn. Stat. § 256B.69, subd. 6A, which requires providers to authorize and provide for the provision of all needed health services in order to ensure appropriate health care for the enrollees. The language proposed is not vague in the legal sense. The question of whether the existing rule or Legal Aid suggestion better implements the statute is a matter of policy for the agency.

51. 9500.1460, subp. 17, deals with the quality assurance system. One provider suggested that provider complaints be included in the system, however, the Department pointed out that it was not germane to this subpart. Another commentor observed that language stating that "the Commissioner may" withhold capitation premiums for deficiencies provides too much discretion and another questioned what standards were to be employed. The Department did agree to delete "the Commissioner may" and provide that if the health plan has failed to correct the deficiency the Commissioner shall withhold all or part of the health plan's capitation premiums until the deficiency is corrected. The modification is not substantial and results in a rule which does not violate substantive law. Legal Aid of Minneapolis had several comments concerning the subpart. It argued that paragraph A. should include a review of the adequacy of service provision by the health plan. It also argued that the rule should affirmatively require the Commissioner to evaluate the health plan's ongoing review in its corrective action plan and to report annually on each plan's review. It was also urged that the rule require an independent audit if the evaluation raised concerns. Finally, it was urged that all information developed be made public. The Northside Minneapolis Legal Aid office supported these comments and argued that only a complete and well-defined quality assurance program will allow the Commissioner and the public to ensure that services provided in PMAP are equal to MA. It suggested that the quality assurance system be submitted for approval by the State and made public. It also suggested detailed standards for adequacy of service provided by the health plan. It was also suggested that a per diem fine be adopted in addition to the sanction of withholding capitation rates.

The Department replied that quality assurance obligations of the health plans are based on federal requirements and are spelled out in great detail in contracts entered into between the health plans and DHS. It suggested that recording all requests for services would be very difficult and noted that health plans are required to submit all complaints received on a bi-yearly

basis. Ex. P, p. 29. It noted that the state conducts an annual independent review of the quality of care provided by health plans and that therefore it is not accurate to say that DHS has delegated to the health plans the responsibility of monitoring the quality of care provided to MA recipients. It noted that each health plan by law is required to provide internal quality assurance monitoring systems in compliance with Department of Health rules. Ex. Q, p. 16. The proposed subpart as modified has been shown to needed and reasonable. The lack of the language suggested by Legal Aid does not render the subpart arbitrary or in violation of any statute. The question of what degree of accountability is appropriate in monitoring the quality assurance system, is a question of policy to be resolved by the Department based upon this rulemaking record.

9500.1462 - Second Medical Opinion

52. One commentor thought the "does not require structured treatment" language was unclear and suggested that second opinions be required when chemical dependency or mental health services are being denied. The Department pointed out, however, that this item is required under Minn. Stat. § 62D.103 and cannot therefore be modified. Ex. Q, p. 5. Legal Aid asked that C. of the rule specify that the information stated be included in the hearing notice. The Department pointed out that is already accomplished by 9500.1463, subp. 4A. The rule is needed and reasonable as proposed. The Department did propose to insert the terms "participating provider" and "non-participating provider" which it has now defined into the rule where appropriate. The change is not substantial.

9500.1463 - Complaint and Appeal Procedures

53. 9500.1463, subp. 3, deals with health plan complaint procedures. Several commentors asked that providers or family members be added in addition to enrollees as persons who can make complaints. The Department declined to do this but did note that appeals can be filed by a family member or a provider if the enrollee has authorized these persons to act on his or her behalf. Ex. Q, p. 9. The subpart is needed and reasonable as proposed.

54. 9500.1463, subp. 4, sets out notice requirements for complaints or appeals. Some of the commentors suggested that this subpart might be more specific and should indicate that the appeal extends to the actions of other participating providers and that approval of a different type or amount of health service than requested was appealable. The Department did not accept the suggestion since it believes that the rule is clear that when a requested service is denied, terminated or reduced, notice must be given to the enrollee. Ex. Q, p. 17. While the language proposed by the Department has been shown to be needed and reasonable, the Department should review suggestions by the Legal Aid Society of Minneapolis to determine if they would result in a clearer rule subpart for health plans, participating providers and enrollees who must utilize the rule. The Department did suggest that some language be deleted from the subpart, however. It suggests deleting "within the time period set forth in its contract" as, presumably unnecessary. Additionally, it suggests deleting "be in a form acceptable to the commissioner and" in order to limit discretion. Ex. P, p. 33. Neither change is substantial.

55. 9500.1463, subp. 5, deals with the state appeal procedure. The Legal Aid Society of Minneapolis argued that the rule subpart is contrary to Minn. Stat. § 256.045, subd. 3, which permits an enrollee to appeal if aggrieved by any ruling of a prepaid health plan. It argued that there are many situations that are not necessarily categorized as reductions or denials where an appeal is allowed such as a failure to prove a type of service or a disagreement with an individual plan of care. It suggested that the rule should specify that any other ruling can be appealed. The Department argues that the language proposed covers the full range of instances where a client could file an appeal. It states that clients have filed appeals that have been heard by state referees with regard to provider preference or unreasonable delays and these issues have been categorized as denial, delay, termination or reduction of services. Ex. Q, p. 17. Minn. Stat. § 256.045, subd. 3, specifically states that, "Any person applying for, receiving or having received public assistance . . . whose application for assistance is denied, not acted upon with reasonable promptness, or whose assistance is suspended, reduced, terminated, or claimed to have been incorrectly paid, . . . or a party aggrieved by a ruling of a prepaid health plan, may contest that action or decision before the state agency. . . ." The proposed rule impermissibly narrows the grounds for appeal. United Hardware Distributing Co. v. Commissioner of Revenue, 284 N.W.2d 820 (Minn. 1979). This is a violation of a substantive provision of law. In order to correct the defect the language "or any other ruling of a prepaid health plan" could be inserted after the word "services".

56. 9500.1463, subp. 6, deals with services pending appeal. Several providers suggested that this subpart specifically state that the health plan must continue to provide "and pay for" services. The Department stated that the current proposed language, "provide", implies liability for payment of services for ongoing services pending the outcome of an appeal. Because this subpart does not deal with unauthorized services and the Department does not wish to interfere with the contractual arrangements between health plans and providers, it did not choose to accept the recommendation. Ex. P, p. 32. The Legal Aid Society of Minneapolis argued that the subpart must allow continuation of services received on an ongoing basis not only as approved by the health plan but also as an MA covered service in order to avoid an equal protection problem. The problem arises when a person on fee-for-service MA moves to a PMAP county. Legal Aid argues that those persons are entitled to have ongoing health services continued pending appeal even though they would not have been ordered by a plan physician. It was also suggested that "ongoing basis" be defined. The Department indicated that it interpreted "ongoing basis" to be those services that have been authorized and are currently being provided by the current health plan. Ex. P, p. 32. SMRLS argued that such an interpretation is inappropriate since the crucial factor is not whether the current health plan has provided the services but rather whether the recipient has been receiving the services on an ongoing basis.

The Department may wish to formulate a definition based upon the comments which have been made for inclusion in its final rule. SMRLS also pointed out what it believes to be a conflict between the 10-day appeal deadline in the proposed rule and a Consent Order in Ramsey County District Court which states that an enrollee need only file a written request for appeal with the state "before the date of the proposed action". Since the terms of the Consent Order potentially would permit a somewhat longer appeal period, the subpart as proposed is in violation of the Consent Order which is a substantive provision

of law. To correct this defect the appeal period should be modified to accommodate the language of the Consent Order. In regard to the equal protection argument, the Department argued that it is not reasonable to mandate that a new health carrier be held liable for services that were prescribed by another physician outside the enrollee's current health plan. It stated that this is true for situations where the clients changed health care systems from either a health plan or fee-for-service. Ex. Q, p. 18. The proposed language is not legally insufficient on these grounds. With the exception of the defect mentioned above, the subpart is needed and reasonable as proposed.

57. 9500.1463, subp. 7, deals with the state omsbundsperson. SMRLS was concerned that the actions of the omsbundsperson could potentially delay an appeal under the proposed language. It therefore suggested language that would permit the omsbundsperson to explain the appeal process immediately if he believed informal resolution was not feasible or appropriate. It was also suggested that the language specifically require the omsbundsperson to assist the enrollee with the appeal. SMRLS suggested that these interpretations were required under the Ramsey County District Court Consent Order. The Department accepted the suggestions and adopted the language suggested by SMRLS. Ex. Q, p. 8. The modifications merely clarify the subpart and are not substantial. So modified, the subpart has been shown to be needed and reasonable.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

CONCLUSIONS

1. That the Department gave proper notice of the hearing in this matter.

2. That the Department has fulfilled the procedural requirements of Minn. Stat. §§ 14.14, subds. 1, 1a and 14.14, subd. 2, and all other procedural requirements of law or rule.

3. That the Department has demonstrated its statutory authority to adopt the proposed rules and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i)(ii), except as noted at Findings of Fact No. 31, No. 55 and No. 56.

4. That the Department has documented the need for and reasonableness of its proposed rules with an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii).

5. That the amendments and additions to the proposed rules which were suggested by the Department after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3, and Minn. Rule 1400.1000, Subp. 1 and 1400.1100.

6. That the Administrative Law Judge has suggested action to correct the defects cited in Conclusion No. 3 as noted at Findings of Fact No. 31, No. 55 and No. 56.

7. That due to Conclusion No. 3, this Report has been submitted to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. § 14.15, subd. 3.

8. That any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Findings are hereby adopted as such.

9. That a finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

It is hereby recommended that the proposed rules be adopted except where specifically otherwise noted above.

Dated this 7 day of June, 1991.

PETER C. ERICKSON
Administrative Law Judge