HOUSE RESEARCH

Bill Summary

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Subject: County-based Purchasing and Managed Care Plans

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Overview

This bill requires the commissioner of human services to assign prepaid MA enrollees who do not choose a managed care plan to county-based purchasing plans, and requires the commissioner to approve a single-plan county-based purchasing proposal. The bill also requires competitive reprocurement every five years, and contains provisions related to the financial management of county-based purchasing plans and managed care plans.

Section

Managed care plans. Amends § 13.461, by adding subd. 24a. States that data provided to the commissioner of human services by managed care plans related to contracts and provider payment rates are classified under § 256B.69, subd. 9b.

1 **Limitation of choice.** Amends § 256B.69, subd. 4. Requires the commissioner of human services to assign prepaid medical assistance program enrollees who do not choose a specific managed care plan to the county-based purchasing plan, in counties that have an approved county-based purchasing plan.

Managed care contracts. Amends § 256B.69, subd. 5a. Requires managed care plans to demonstrate to the commissioner that the data submitted related to attainment of performance targets is accurate. Requires the commissioner to periodically change the administrative measures used as performance targets. Requires performance targets to include measurement of plan efforts to contain spending on health care services and administrative activities. Allows the commissioner to adopt plan-specific performance targets that may include characteristics of the plan's population.

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Administrative expenses. Amends § 256B.69, by adding subd. 5i. (a) Prohibits managed care and county-based purchasing plan administrative costs from exceeding the previous year's costs by more than 5 percent, when calculated as a percentage of total revenue. Sets the penalty for exceeding this limit as the amount of administrative spending in excess of 105 percent of the calculated amount. Allows the commissioner to waive this penalty if excess spending is due to unexpected shifts in enrollment, member needs, or new program requirements.

(b) Requires capitated payments for administrative costs to be reduced to exclude onetime or sporadic expenditures in the prior year, unless the plan certifies that these expenditures will recur during the contract year. Requires the commissioner to verify these certifications and to recoup payments as necessary.

(c) Provides that payments to charitable, educational, religious, or educational organizations are not allowable administrative expenses for rate-setting, unless approved by the commissioner.

Treatment of investment earnings. Amends § 256B.69, by adding subd. 5j. States that capitation rates shall treat investment income and interest earnings as income, to the same extent that investment-related expenses are treated as administrative expenditures.

Administrative expense reporting. Amends § 256B.69, by adding subd. 9a. Requires managed care and county-based purchasing plans to provide to the commissioner detailed information on administrative spending, including information on: (1) costs of claims processing and provider network management; (2) costs for contracts with providers and third-party administrators; (3) administrative spending by health care programs; (4) allocation of administrative expenses among public and commercial lines of business; (5) administrative costs by service category; and (6) onetime and sporadic expenditures.

Reporting of subcontracts and provider payment rates. Amends § 256B.69, by adding subd. 9b. Requires managed care and county-based purchasing plans to provide the commissioner detailed information on contracts with health care providers and reimbursement rates paid to providers under contract. Classifies this information as nonpublic data.

Duties of the commissioner of health. Amends § 256b.692, subd. 2. Effective January 1, 2010 , requires county-based purchasing plans to meet the fiscal solvency requirements that apply to HMOs, and specifies a phase-in schedule for meeting these requirements. (Under current law, county-based purchasing plans have the option of meeting the requirements applicable to community integrated service networks under chapter 62N.)

Expenditure of revenues. Amends § 256B.692, by adding subd. 4a. Requires counties operating county-based purchasing plans to use any excess revenues not needed for capital reserves, to increase payments to providers, or repay county investments or contributions to the plan, for prevention, early intervention, and health care programs, services, or activities. States that a county-based purchasing plan is subject to the unreasonable expense provisions that apply to HMOs.

Rate setting; performance withholds. Amends § 256L.12, subd. 9. Requires county-based purchasing plans to demonstrate to the commissioner that the data submitted related to attainment of performance targets is accurate. Requires the commissioner to periodically change the administrative measures used as performance targets. Requires performance targets to include measurement of plan efforts to contain spending on health care services

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and administrative activities. Allows the commissioner to adopt plan-specific performance targets that may include characteristics of the plan's population.

2 **Sole-source or single-plan managed care contract.** Amends Laws 2005, First Special Session chapter 4, article 8, section 84, as further amended. The amendment to paragraph (a) requires the commissioner of human services to approve a county-based purchasing health plan proposal submitted on behalf of Winona, Houston, Fillmore, and Mower counties for MA, MinnesotaCare, GAMC, and other state prepaid health care programs, that requires county-based purchasing on a single-plan basis contract, if implementation does not limit an enrollee's choice of provider or access to services, and if all other requirements related to health plan purchasing are met. This section provides an exemption from current law (§ 256B.692, subd. 6, clause (1), paragraph (c)), under which the commissioner may reject proposals that "would substantially impair an enrollee's choice of care systems when reasonable choice is possible."

A new paragraph (c) requires the commissioner to reopen all counties for competitive reprocurement every five years, beginning in 2011.

The amendment to paragraph (d) strikes an outdated reporting requirement.

Report on financial management of health care programs. Requires the commissioner of human services to report to the legislature by January 15, 2009, on the following topics related to the financial management of health care programs: (1) a status report on implementation of the cost containment strategies identified in the 2005 "Strategies for Savings" report; (2) a description and explanation of differences between health plan net revenue targets for public programs and the actual net revenue realized; (3) the adequacy of public health care program fee-for-service rates, including an identification of service areas or regions in which inadequate rates lead to access problems and recommendations to increase rates to eliminate access problems; and (4) a progress report on implementation of a Medicare relative value unit payment system for physician and professional services.

Health plan and county-based purchasing plan requirements. (a) Requires the commissioner of health to report to the legislature, by January 15, 2009 , guidelines to ensure that health plans and county-based purchasing plans have consistent procedures for allocating administrative expenses and investment income across their commercial and public lines of business and across individual public programs. Specifies criteria for guidelines.

(b) Requires the commissioner of health, in cooperation with the commissioners of commerce and human services, to report to the legislature by January 15, 2009, standards and procedures for examining the reasonableness of health plan and county-based purchasing plan administrative expenditures for public programs.

(c) Requires the commissioner of health to report to the legislature by January 15, 2009 , on a more efficient method for health plans and county-based purchasing plans to demonstrate to the commissioner that network providers have appropriate credentials. Lists issues for review.

Ombudsman for managed care study. Requires the commissioner of human services, in cooperation with the ombudsman for managed care, to report to the legislature by January 15, 2009 , recommendations on whether the duties of the ombudsman should be expanded

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to include advocating on behalf of public program fee-for-service enrollees. Lists criteria for the report.

Reporting on managed care performance data. Requires the commissioner of human services, in cooperation with the commissioner of health, to report to the legislature by January 15, 2009 , recommendations on a single method to compute and publicly report managed heath care performance measures. Requires the study to include recommendations on coordinated use by the two agencies of specified data sources.