House Research
Act Summary

CHAPTER: 364 **SESSION:** 2008 Regular Session

TOPIC: State health care program financial management; County-based purchasing

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Overview

The act contains provisions related to the financial management of county-based purchasing plans and managed care plans. The act also modifies single plan county-based purchasing arrangements.

Section

1 **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, subdivisions 9a and 9b.

2 **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 take into account factors affecting only one plan, including characteristics of the plan's population.

3 **Administrative expenses.** Amends § 256B.69, by adding subd. 5i. (a) Prohibits managed care and county-based purchasing plan administrative costs from exceeding the previous calendar 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) Provides that payments to charitable, educational, religious, or educational organizations are not allowable administrative expenses for rate-setting, unless approved by the commissioner.

4 **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.

5 **Administrative expense reporting.** Amends § 256B.69, by adding subd. 9a. Requires the commissioner of human services, within the limit of available appropriations, to work with the commissioner of health to identify and collect data on administrative spending for state health care programs reported by managed care and county-based purchasing plans, provided that the data are consistent with guidelines and standards developed by the commissioner of health and reported to the legislature under section 12. Classifies this data as nonpublic. Provides a July 1, 2009 effective date.

6 **Reporting provider payment rates.** Amends § 256B.69, by adding subd. 9b. Requires managed care and county-based purchasing plans to provide the commissioner, at the commissioner's request, detailed or aggregate information on reimbursement rates paid to providers and vendors for administrative services. Classifies this information as nonpublic data. Provides a January 1, 2010 effective date.

7 **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.) Requires the commissioner to collect the following fees from county-based purchasing plans: (1) fees attributable to the cost of audits and other examinations; (2) an annual fee of $21,500; and (3) for fiscal year 2009 only, a per-enrollee fee of 14.6 cents. Requires fees to be deposited in the state government special revenue fund.

8 **Expenditure of revenues.** Amends § 256B.692, by adding subd. 4a. Requires counties operating county-based purchasing plans to use any excess revenues not needed: (1) for capital reserves; (2) to increase payments to providers; or (3) to 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.

9 **Rate setting; performance withholds.** Amends § 256L.12, subd. 9. 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 take into account factors affecting only one plan, such as characteristics of the plan's population.

10 **Sole-source or single-plan managed care contract.** Amends Laws 2005, First Special Session chapter 4, article 8, section 84, as amended. The amendment to paragraph (a) requires the commissioner of human services to continue single plan county-based purchasing arrangements for MA and GAMC programs and products that were in effect on March 1, 2008. States that this paragraph does not require termination of contracts with noncounty-based purchasing plans that had enrollment in an MA program or product on March 1, 2008. Provides that the paragraph expires December 31, 2010, or on the effective

date of a new MA or GAMC contract entered into at the conclusion of the commissioner's next scheduled reprocurement process, whichever is later.

The amendment to paragraph (b) provides that provisions related to serving persons with disabilities on a single-plan basis do not supersede or modify the requirements in paragraph (a), and also strikes an outdated reporting requirement.

11 **Report on financial management of health care programs.** Requires the commissioner of human services, within the limits of available appropriations, 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.

12 **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. Requires the report to include recommendations and cost estimates for developing detailed standards and procedures for examining the reasonableness of health plan and county-based purchasing plan administrative expenditures for public programs.

13 **Ombudsman for managed care study.** Within the limits of available appropriations, 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 to include advocating on behalf of public program fee-for-service enrollees. Lists criteria for the report.

14 **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.

15 **Credentialing methodology.** Requires the commissioner of human services to explore the feasibility of using or coordinating with the credentialing collaborative between Minnesota payers, providers, and hospitals, in order to make the provider enrollment process for Minnesota health care programs more efficient. Requires the commissioner to report to the relevant legislative committee chairs by December 15, 2009.

16 **Health maintenance organization renewal fee.** Increases the HMO renewal fee by 14.6 cents from the level in effect on June 30, 2008, for fiscal year 2009. Specifies that the fee reverts to its previous level for future fiscal years.

17 **Appropriations.**

(a) Appropriates $261,000 from the state government special revenue fund to the commissioner of health for this act, for fiscal year 2009. Specifies that base level funding is $77,000.

(b) Specifies that of the appropriation in paragraph (a), $116,000 in fiscal year 2009 is for

the study and report required by section 12, $145,000 in fiscal year 2009 shall be transferred to the general fund, and $77,000 shall be transferred each fiscal year beginning on or after July 1, 2009.

(c) Appropriates $145,000 from the general fund to the commissioner of human services for fiscal year 2009 for actuarial and other costs. Specifies that base level funding is $135,000.

(d) Appropriates $96,000 from the general fund to the commissioner of human services for fiscal year 2009, for the study required by section 11, clause (3).