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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 2038

03/19/2015 Authored by Dean, M.,

The bill was read for the first time and referred to the Committee on Health and Human Services Reform

03/25/2015 Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance

1.1 A bill for an act
1.2 relating to human services; modifying and clarifying financial reporting
1.3 requirements for managed care and county-based purchasing plans serving
1.4 state public program enrollees; setting requirements related to subcontracts;
1.5 modifying requirements related to administrative costs; clarifying not allowable
1.6 administrative expenses; requiring third-party financial audits and ad hoc audits;
1.7 amending Minnesota Statutes 2014, sections 62D.08, subdivision 7; 256B.69,
1.8 subdivisions 5a, 5i, 9c, 9d, by adding a subdivision; Laws 2008, chapter 363,
1.9 article 18, section 3, subdivision 5.

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

1.11 Section 1. Minnesota Statutes 2014, section 62D.08, subdivision 7, is amended to read:

1.12 Subd. 7. **Consistent administrative expenses and investment income reporting.**

1.13 (a) Every health maintenance organization must submit financial information, including
1.14 administrative expenses for dental services, using the reporting template Minnesota
1.15 Supplement Report #1A provided by the commissioner of health. Every health maintenance
1.16 organization must directly allocate administrative expenses to specific lines of business,
1.17 product, or products individual state public program when such information is available.
1.18 Remaining expenses that cannot be directly allocated must be allocated based on other
1.19 methods, as recommended by the Advisory Group on Administrative Expenses by dollars
1.20 of premium income or by administrative revenue for administrative services only (ASO)
1.21 business lines. Health maintenance organizations must submit this information, including
1.22 administrative expenses for dental services, using the reporting template provided by the
1.23 commissioner of health. Investment gain must be allocated annually based on premium
1.24 revenue dedicated to each business line, product, and individual state public program. The
1.25 Minnesota Supplement Report #1A categorized administrative expenses must reconcile to
1.26 the general administrative expenses reported on line 21 on Minnesota Supplement Report

2.1 #1, as well as the underwriting and investment exhibit part 3 - analysis of expenses, of
 2.2 the NAIC health blank. The Minnesota Supplement Report #1A categories include the
 2.3 following expense categories from the underwriting and investment exhibit part 3:

2.4 (1) employee benefit expenses: salaries, wages, and benefits;

2.5 (2) sales expenses: commissions, marketing, and advertising; cost of sales-related
 2.6 materials, postage, telephone, and printing materials;

2.7 (3) general business and office type expenses: rent; non-sales-related postage,
 2.8 express, and telephone; non-sales-related printing and office supplies; taxes, excluding state
 2.9 premium taxes and assessments; licenses and fees; traveling expenses; insurance, except on
 2.10 real estate; collection and bank service charges; group service and administration fees; real
 2.11 estate expenses; real estate taxes; equipment; occupancy, depreciation and amortization;
 2.12 cost or depreciation of electronic data processing (EDP) equipment and software;

2.13 (4) state premium taxes and assessments;

2.14 (5) consulting and professional fees: legal fees and expenses; certifications and
 2.15 accreditation fees; auditing, actuarial, and other consulting fees; board, bureau, and
 2.16 association fees;

2.17 (6) outsourced services: EDP; claims and other services; and

2.18 (7) other expenses: investment expenses not included elsewhere; aggregate
 2.19 write-ins for expenses; reimbursements by uninsured plans; reimbursements from fiscal
 2.20 intermediaries.

2.21 ~~(b) Every health maintenance organization must allocate investment income based~~
 2.22 ~~on cumulative net income over time by business line or product and must submit this~~
 2.23 ~~information, including investment income for dental services, using the reporting template~~
 2.24 ~~provided by the commissioner of health. For purposes of this subdivision:~~

2.25 (1) "directly allocate" means to assign costs for an item to a specific product or
 2.26 individual state public program when the cost can be specifically identified with, and
 2.27 benefits, the particular product or individual state public program, and the allocated costs
 2.28 are based on the relative benefits received; and

2.29 (2) "individual state public program" means each medical assistance program,
 2.30 including the prepaid medical assistance program, Minnesota senior health options,
 2.31 Minnesota senior care plus, and special needs basic care; and the MinnesotaCare program.

2.32 Sec. 2. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

2.33 Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section
 2.34 and section 256L.12 shall be entered into or renewed on a calendar year basis. The

3.1 commissioner may issue separate contracts with requirements specific to services to
3.2 medical assistance recipients age 65 and older.

3.3 (b) A prepaid health plan providing covered health services for eligible persons
3.4 pursuant to chapters 256B and 256L is responsible for complying with the terms of its
3.5 contract with the commissioner. Requirements applicable to managed care programs
3.6 under chapters 256B and 256L established after the effective date of a contract with the
3.7 commissioner take effect when the contract is next issued or renewed.

3.8 (c) The commissioner shall withhold five percent of managed care plan payments
3.9 under this section and county-based purchasing plan payments under section 256B.692
3.10 for the prepaid medical assistance program pending completion of performance targets.
3.11 Each performance target must be quantifiable, objective, measurable, and reasonably
3.12 attainable, except in the case of a performance target based on a federal or state law
3.13 or rule. Criteria for assessment of each performance target must be outlined in writing
3.14 prior to the contract effective date. Clinical or utilization performance targets and their
3.15 related criteria must consider evidence-based research and reasonable interventions when
3.16 available or applicable to the populations served, and must be developed with input from
3.17 external clinical experts and stakeholders, including managed care plans, county-based
3.18 purchasing plans, and providers. The managed care or county-based purchasing plan
3.19 must demonstrate, to the commissioner's satisfaction, that the data submitted regarding
3.20 attainment of the performance target is accurate. The commissioner shall periodically
3.21 change the administrative measures used as performance targets in order to improve plan
3.22 performance across a broader range of administrative services. The performance targets
3.23 must include measurement of plan efforts to contain spending on health care services and
3.24 administrative activities. The commissioner may adopt plan-specific performance targets
3.25 that take into account factors affecting only one plan, including characteristics of the
3.26 plan's enrollee population. The withheld funds must be returned no sooner than July of the
3.27 following year if performance targets in the contract are achieved. The commissioner may
3.28 exclude special demonstration projects under subdivision 23.

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

3.35 (e) Effective for services rendered on or after January 1, 2012, the commissioner
3.36 shall include as part of the performance targets described in paragraph (c) a reduction

4.1 in the health plan's emergency department utilization rate for medical assistance and
4.2 MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction
4.3 shall be based on the health plan's utilization in 2009. To earn the return of the withhold
4.4 each subsequent year, the managed care plan or county-based purchasing plan must
4.5 achieve a qualifying reduction of no less than ten percent of the plan's emergency
4.6 department utilization rate for medical assistance and MinnesotaCare enrollees, excluding
4.7 enrollees in programs described in subdivisions 23 and 28, compared to the previous
4.8 measurement year until the final performance target is reached. When measuring
4.9 performance, the commissioner must consider the difference in health risk in a managed
4.10 care or county-based purchasing plan's membership in the baseline year compared to the
4.11 measurement year, and work with the managed care or county-based purchasing plan to
4.12 account for differences that they agree are significant.

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

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

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

5.1 The withheld funds must be returned no sooner than July 1 and no later than July
5.2 31 of the following calendar year if the managed care plan or county-based purchasing
5.3 plan demonstrates to the satisfaction of the commissioner that this reduction in the
5.4 hospitalization rate was achieved. The commissioner shall structure the withhold so that
5.5 the commissioner returns a portion of the withheld funds in amounts commensurate with
5.6 achieved reductions in utilization less than the targeted amount.

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

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

5.24 The withheld funds must be returned no sooner than July 1 and no later than July
5.25 31 of the following calendar year if the managed care plan or county-based purchasing
5.26 plan demonstrates to the satisfaction of the commissioner that a qualifying reduction in
5.27 the subsequent hospitalization rate was achieved. The commissioner shall structure the
5.28 withhold so that the commissioner returns a portion of the withheld funds in amounts
5.29 commensurate with achieved reductions in utilization less than the targeted amount.

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

6.1 (h) Effective for services rendered on or after January 1, 2013, through December
6.2 31, 2013, the commissioner shall withhold 4.5 percent of managed care plan payments
6.3 under this section and county-based purchasing plan payments under section 256B.692
6.4 for the prepaid medical assistance program. The withheld funds must be returned no
6.5 sooner than July 1 and no later than July 31 of the following year. The commissioner may
6.6 exclude special demonstration projects under subdivision 23.

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

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

6.16 (k) Contracts between the commissioner and a prepaid health plan are exempt from
6.17 the set-aside and preference provisions of section 16C.16, subdivisions 6, paragraph
6.18 (a), and 7.

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

6.21 (m) Managed care plans and county-based purchasing plans shall maintain current
6.22 and fully executed agreements for all subcontractors, including bargaining groups, for
6.23 administrative services that are expensed to the state's public programs. Subcontractor
6.24 agreements must be in the form of a written instrument or electronic document containing
6.25 the elements of offer, acceptance, and consideration, and include sufficient detail on
6.26 payment terms, scope, and duration of the contract to verify the payment amounts and how
6.27 the subcontractor services relate to state public programs. Upon request, the commissioner
6.28 shall have access to all subcontractor documentation under this paragraph. Nothing in this
6.29 paragraph shall allow release of information that is nonpublic data pursuant to section
6.30 13.02.

6.31 Sec. 3. Minnesota Statutes 2014, section 256B.69, subdivision 5i, is amended to read:

6.32 Subd. 5i. **Administrative expenses.** ~~(a) Managed care plan and county-based~~
6.33 ~~purchasing plan~~ Administrative costs for a prepaid health plan provided paid to managed
6.34 care plans under this section or, section 256B.692, or section 256L.12 must not exceed by
6.35 more than five 6.6 percent that prepaid health plan's or county-based purchasing plan's

7.1 ~~actual calculated administrative spending for the previous calendar year as a percentage~~
7.2 ~~of total revenue~~ of total managed care plan payments in aggregate across all state public
7.3 programs for each calendar year. The penalty for exceeding this limit must be the amount
7.4 of administrative spending in excess of 105 percent of the actual calculated amount.
7.5 ~~The commissioner may waive this penalty if the excess administrative spending is the~~
7.6 ~~result of unexpected shifts in enrollment or member needs or new program requirements.~~
7.7 The commissioner may reduce or eliminate administrative requirements to meet the
7.8 administrative cost limit. For purposes of this paragraph, administrative costs do not
7.9 include premium taxes paid under section 2971.05, subdivision 5, and provider surcharges
7.10 paid under section 256.9657, subdivision 3.

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

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

7.15 (2) any portion of an individual's compensation in excess of \$200,000 paid by the
7.16 managed care plan or county-based purchasing plan, inclusive of all individual state
7.17 public programs;

7.18 (3) any penalties or fines assessed against the managed care plan or county-based
7.19 purchasing plan; ~~and~~

7.20 (4) any indirect marketing or advertising expenses of the managed care plan or
7.21 county-based purchasing plan, including but not limited to costs to promote the managed
7.22 care plan, costs of facilities used and related to special events, displays, demonstrations,
7.23 donations, and promotional items, such as memorabilia, models, gifts, and souvenirs;

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

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

7.27 (7) alcoholic beverages and related costs;

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

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

7.32 For the purposes of this subdivision, compensation includes salaries, bonuses and
7.33 incentives, other reportable compensation on an IRS 990 form, retirement and other
7.34 deferred compensation, and nontaxable benefits. Contributions include payments for
7.35 or to any organization or entity selected by the health maintenance organization that is
7.36 operated for charitable, educational, political, religious, or scientific purposes and not

8.1 related to the provision of medical and administrative services covered under the medical
8.2 assistance and MinnesotaCare programs.

8.3 (c) For administrative services expensed to the state's public programs, managed
8.4 care plans and county-based purchasing plans must clearly identify and separately record
8.5 expense items listed under paragraph (b) in their accounting systems in a manner that
8.6 allows for independent verification of unallowable expenses for purposes of determining
8.7 payment rates for state public health care programs.

8.8 Sec. 4. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

8.9 Subd. 9c. **Managed care financial reporting.** (a) The commissioner shall collect
8.10 detailed data regarding financials, provider payments, provider rate methodologies, and
8.11 other data as determined by the commissioner. The commissioner, in consultation with the
8.12 commissioners of health and commerce, and in consultation with managed care plans and
8.13 county-based purchasing plans, shall set uniform criteria, definitions, and standards for the
8.14 data to be submitted, and shall require managed care and county-based purchasing plans
8.15 to comply with these criteria, definitions, and standards when submitting data under this
8.16 section. In carrying out the responsibilities of this subdivision, the commissioner shall
8.17 ensure that the data collection is implemented in an integrated and coordinated manner
8.18 that avoids unnecessary duplication of effort. To the extent possible, the commissioner
8.19 shall use existing data sources and streamline data collection in order to reduce public
8.20 and private sector administrative costs. Nothing in this subdivision shall allow release of
8.21 information that is nonpublic data pursuant to section 13.02.

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

- 8.27 (1) an income statement by program;
- 8.28 (2) financial statement footnotes;
- 8.29 (3) quarterly profitability by program and population group;
- 8.30 (4) a medical liability summary by program and population group;
- 8.31 (5) received but unpaid claims report by program;
- 8.32 (6) services versus payment lags by program for hospital services, outpatient
8.33 services, physician services, other medical services, and pharmaceutical benefits;

9.1 (7) utilization reports that summarize utilization and unit cost information by
9.2 program for hospitalization services, outpatient services, physician services, and other
9.3 medical services;

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

9.6 (9) subcapitation expenses by population group;

9.7 (10) third-party payments by program;

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

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

9.10 (13) medical loss ratios by program;

9.11 (14) administrative expenses by category and subcategory by program that reconcile
9.12 to other state and federal regulatory agencies;

9.13 (15) revenues by program, including investment income;

9.14 (16) nonadministrative service payments, provider payments, and reimbursement
9.15 rates by provider type or service category, by program, paid by the managed care plan
9.16 under this section or the county-based purchasing plan under section 256B.692 to
9.17 providers and vendors for administrative services under contract with the plan, including
9.18 but not limited to:

9.19 (i) individual-level provider payment and reimbursement rate data;

9.20 (ii) provider reimbursement rate methodologies by provider type, by program,
9.21 including a description of alternative payment arrangements and payments outside the
9.22 claims process;

9.23 (iii) data on implementation of legislatively mandated provider rate changes; and

9.24 (iv) individual-level provider payment and reimbursement rate data and plan-specific
9.25 provider reimbursement rate methodologies by provider type, by program, including
9.26 alternative payment arrangements and payments outside the claims process, provided to
9.27 the commissioner under this subdivision are nonpublic data as defined in section 13.02;

9.28 (17) data on the amount of reinsurance or transfer of risk by program; and

9.29 (18) contribution to reserve, by program.

9.30 (c) In the event a report is published or released based on data provided under
9.31 this subdivision, the commissioner shall provide the report to managed care plans and
9.32 county-based purchasing plans 15 days prior to the publication or release of the report.
9.33 Managed care plans and county-based purchasing plans shall have 15 days to review the
9.34 report and provide comment to the commissioner.

9.35 The quarterly reports shall be submitted to the commissioner no later than 60 days after the
9.36 end of the previous quarter, except the fourth-quarter report, which shall be submitted by

10.1 April 1 of each year. The fourth-quarter report shall include audited financial statements,
10.2 parent company audited financial statements, an income statement reconciliation report,
10.3 and any other documentation necessary to reconcile the detailed reports to the audited
10.4 financial statements.

10.5 (d) Managed care plans and county-based plans shall certify to the commissioner
10.6 for the purposes of financial reporting for state public health care programs under this
10.7 subdivision, and for reporting to the commissioner of health under section 62D.08, that
10.8 costs reported for state public health care programs include:

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

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

10.13 Sec. 5. Minnesota Statutes 2014, section 256B.69, subdivision 9d, is amended to read:

10.14 Subd. 9d. **Financial audit and quality assurance audits.** ~~(a) The legislative~~
10.15 ~~auditor shall contract with an audit firm to conduct a biennial independent third-party~~
10.16 ~~financial audit of the information required to be provided by managed care plans and~~
10.17 ~~county-based purchasing plans under subdivision 9c, paragraph (b). The audit shall be~~
10.18 ~~conducted in accordance with generally accepted government auditing standards issued~~
10.19 ~~by the United States Government Accountability Office. The contract with the audit~~
10.20 ~~firm shall be designed and administered so as to render the independent third-party audit~~
10.21 ~~eligible for a federal subsidy, if available. The contract shall require the audit to include~~
10.22 ~~a determination of compliance with the federal Medicaid rate certification process. The~~
10.23 ~~contract shall require the audit to determine if the administrative expenses and investment~~
10.24 ~~income reported by the managed care plans and county-based purchasing plans are~~
10.25 ~~compliant with state and federal law.~~

10.26 ~~(b) For purposes of this subdivision, "independent third party" means an audit firm~~
10.27 ~~that is independent in accordance with government auditing standards issued by the United~~
10.28 ~~States Government Accountability Office and licensed in accordance with chapter 326A.~~
10.29 ~~An audit firm under contract to provide services in accordance with this subdivision must~~
10.30 ~~not have provided services to a managed care plan or county-based purchasing plan during~~
10.31 ~~the period for which the audit is being conducted.~~

10.32 ~~(c) (a)~~ The commissioner shall require, in the request for bids and resulting contracts
10.33 with managed care plans and county-based purchasing plans under this section and
10.34 section 256B.692, that each managed care plan and county-based purchasing plan submit
10.35 to and fully cooperate with the independent third-party financial ~~audit~~ audits by the

11.1 legislative auditor under subdivision 9e of the information required under subdivision 9c,
 11.2 paragraph (b). Each contract with a managed care plan or county-based purchasing plan
 11.3 under this section or section 256B.692 must provide the commissioner and the ~~audit firm~~
 11.4 vendors contracting with the legislative auditor access to all data required to complete
 11.5 ~~the audit. For purposes of this subdivision, the contracting audit firm shall have the same~~
 11.6 ~~investigative power as the legislative auditor under section 3.978, subdivision 2~~ audits
 11.7 under subdivision 9e.

11.8 ~~(d)~~ (b) Each managed care plan and county-based purchasing plan providing services
 11.9 under this section shall provide to the commissioner biweekly encounter data and claims
 11.10 data for state public health care programs and shall participate in a quality assurance
 11.11 program that verifies the timeliness, completeness, accuracy, and consistency of the data
 11.12 provided. The commissioner shall develop written protocols for the quality assurance
 11.13 program and shall make the protocols publicly available. The commissioner shall contract
 11.14 for an independent third-party audit to evaluate the quality assurance protocols as to
 11.15 the capacity of the protocols to ensure complete and accurate data and to evaluate the
 11.16 commissioner's implementation of the protocols. ~~The audit firm under contract to provide~~
 11.17 ~~this evaluation must meet the requirements in paragraph (b).~~

11.18 ~~(e)~~ (c) ~~Upon completion of the audit under paragraph (a) and receipt by the legislative~~
 11.19 ~~auditor, the legislative auditor shall provide copies of the audit report to the commissioner,~~
 11.20 ~~the state auditor, the attorney general, and the chairs and ranking minority members of the~~
 11.21 ~~health and human services finance committees of the legislature.~~ (c) Upon completion
 11.22 of the evaluation under paragraph ~~(d)~~ (b), the commissioner shall provide copies of the
 11.23 report to the legislative auditor and the chairs and ranking minority members of the ~~health~~
 11.24 ~~finance committees of the legislature~~ legislative committees with jurisdiction over health
 11.25 care policy and financing.

11.26 ~~(f)~~ (d) Any actuary under contract with the commissioner to provide actuarial
 11.27 services must meet the independence requirements under the professional code for fellows
 11.28 in the Society of Actuaries and must not have provided actuarial services to a managed
 11.29 care plan or county-based purchasing plan that is under contract with the commissioner
 11.30 pursuant to this section and section 256B.692 during the period in which the actuarial
 11.31 services are being provided. An actuary or actuarial firm meeting the requirements
 11.32 of this paragraph must certify and attest to the rates paid to the managed care plans
 11.33 and county-based purchasing plans under this section and section 256B.692, and the
 11.34 certification and attestation must be auditable.

11.35 (e) The commissioner shall conduct ad hoc audits of managed care organizations'
 11.36 administrative and medical expenses. This includes: financial and encounter data

12.1 reported to the commissioner under subdivision 9c, including payments to providers
 12.2 and subcontractors; supporting documentation for expenditures; categorization
 12.3 of administrative and medical expenses; and allocation methods used to attribute
 12.4 administrative expenses to state public programs. These audits also must monitor
 12.5 compliance with data and financial certifications provided to the commissioner for the
 12.6 purposes of managed care capitation payment rate-setting. The managed care plans and
 12.7 county-based purchasing plans shall fully cooperate with the audits in this subdivision.
 12.8 The commissioner shall impose a financial penalty for plans that fail to comply with
 12.9 this subdivision.

12.10 ~~(g)~~ (f) Nothing in this subdivision shall allow the release of information that is
 12.11 nonpublic data pursuant to section 13.02.

12.12 Sec. 6. Minnesota Statutes 2014, section 256B.69, is amended by adding a subdivision
 12.13 to read:

12.14 Subd. 9e. **Financial audits.** (a) The legislative auditor shall contract with vendors
 12.15 to conduct independent third-party financial audits of the information required to be
 12.16 provided by managed care plans and county-based purchasing plans under subdivision
 12.17 9c, paragraph (b). The audits by the vendors shall be conducted as vendor resources
 12.18 permit and in accordance with generally accepted government auditing standards issued
 12.19 by the United States Government Accountability Office. The contract with the vendors
 12.20 shall be designed and administered so as to render the independent third-party audits
 12.21 eligible for a federal subsidy, if available. The contract shall require the audits to include a
 12.22 determination of compliance with the federal Medicaid rate certification process.

12.23 (b) For purposes of this subdivision, "independent third-party" means a vendor that
 12.24 is independent in accordance with government auditing standards issued by the United
 12.25 States Government Accountability Office.

12.26 Sec. 7. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

12.27 Subd. 5. **Basic Health Care Grants**

12.28 (a) **MinnesotaCare Grants**

12.29 **Health Care Access** -0- (770,000)

12.30 **Incentive Program and Outreach Grants.**

12.31 Of the appropriation for the Minnesota health
 12.32 care outreach program in Laws 2007, chapter

13.1 147, article 19, section 3, subdivision 7,
 13.2 paragraph (b):
 13.3 (1) \$400,000 in fiscal year 2009 from the
 13.4 general fund and \$200,000 in fiscal year 2009
 13.5 from the health care access fund are for the
 13.6 incentive program under Minnesota Statutes,
 13.7 section 256.962, subdivision 5. For the
 13.8 biennium beginning July 1, 2009, base level
 13.9 funding for this activity shall be \$360,000
 13.10 from the general fund and \$160,000 from the
 13.11 health care access fund; and

13.12 (2) \$100,000 in fiscal year 2009 from the
 13.13 general fund and \$50,000 in fiscal year 2009
 13.14 from the health care access fund are for the
 13.15 outreach grants under Minnesota Statutes,
 13.16 section 256.962, subdivision 2. For the
 13.17 biennium beginning July 1, 2009, base level
 13.18 funding for this activity shall be \$90,000
 13.19 from the general fund and \$40,000 from the
 13.20 health care access fund.

13.21 **(b) MA Basic Health Care Grants - Families**
 13.22 **and Children**

-0- (17,280,000)

13.23 **Third-Party Liability.** (a) During
 13.24 fiscal year 2009, the commissioner shall
 13.25 employ a contractor paid on a percentage
 13.26 basis to improve third-party collections.
 13.27 Improvement initiatives may include, but not
 13.28 be limited to, efforts to improve postpayment
 13.29 collection from nonresponsive claims and
 13.30 efforts to uncover third-party payers the
 13.31 commissioner has been unable to identify.

13.32 (b) In fiscal year 2009, the first \$1,098,000
 13.33 of recoveries, after contract payments and
 13.34 federal repayments, is appropriated to

14.1 the commissioner for technology-related
14.2 expenses.

14.3 ~~**Administrative Costs.** (a) For contracts~~
14.4 ~~effective on or after January 1, 2009,~~
14.5 ~~the commissioner shall limit aggregate~~
14.6 ~~administrative costs paid to managed care~~
14.7 ~~plans under Minnesota Statutes, section~~
14.8 ~~256B.69, and to county-based purchasing~~
14.9 ~~plans under Minnesota Statutes, section~~
14.10 ~~256B.692, to an overall average of 6.6 percent~~
14.11 ~~of total contract payments under Minnesota~~
14.12 ~~Statutes, sections 256B.69 and 256B.692,~~
14.13 ~~for each calendar year. For purposes of~~
14.14 ~~this paragraph, administrative costs do not~~
14.15 ~~include premium taxes paid under Minnesota~~
14.16 ~~Statutes, section 297I.05, subdivision 5, and~~
14.17 ~~provider surcharges paid under Minnesota~~
14.18 ~~Statutes, section 256.9657, subdivision 3.~~

14.19 ~~(b) Notwithstanding any law to the contrary,~~
14.20 ~~the commissioner may reduce or eliminate~~
14.21 ~~administrative requirements to meet the~~
14.22 ~~administrative target under paragraph (a).~~

14.23 ~~(c) Notwithstanding any contrary provision~~
14.24 ~~of this article, this rider shall not expire.~~

14.25 **Hospital Payment Delay.** Notwithstanding
14.26 Laws 2005, First Special Session chapter 4,
14.27 article 9, section 2, subdivision 6, payments
14.28 from the Medicaid Management Information
14.29 System that would otherwise have been made
14.30 for inpatient hospital services for medical
14.31 assistance enrollees are delayed as follows:
14.32 (1) for fiscal year 2008, June payments must
14.33 be included in the first payments in fiscal
14.34 year 2009; and (2) for fiscal year 2009,
14.35 June payments must be included in the first

15.1 payment of fiscal year 2010. The provisions
 15.2 of Minnesota Statutes, section 16A.124,
 15.3 do not apply to these delayed payments.
 15.4 Notwithstanding any contrary provision in
 15.5 this article, this paragraph expires on June
 15.6 30, 2010.

15.7 (c) MA Basic Health Care Grants - Elderly and		
15.8 Disabled	(14,028,000)	(9,368,000)

15.9 **Minnesota Disability Health Options Rate**

15.10 **Setting Methodology.** The commissioner
 15.11 shall develop and implement a methodology
 15.12 for risk adjusting payments for community
 15.13 alternatives for disabled individuals (CADI)
 15.14 and traumatic brain injury (TBI) home
 15.15 and community-based waiver services
 15.16 delivered under the Minnesota disability
 15.17 health options program (MnDHO) effective
 15.18 January 1, 2009. The commissioner shall
 15.19 take into account the weighting system used
 15.20 to determine county waiver allocations in
 15.21 developing the new payment methodology.
 15.22 Growth in the number of enrollees receiving
 15.23 CADI or TBI waiver payments through
 15.24 MnDHO is limited to an increase of 200
 15.25 enrollees in each calendar year from January
 15.26 2009 through December 2011. If those limits
 15.27 are reached, additional members may be
 15.28 enrolled in MnDHO for basic care services
 15.29 only as defined under Minnesota Statutes,
 15.30 section 256B.69, subdivision 28, and the
 15.31 commissioner may establish a waiting list for
 15.32 future access of MnDHO members to those
 15.33 waiver services.

15.34 **MA Basic Elderly and Disabled**

15.35 **Adjustments.** For the fiscal year ending June
 15.36 30, 2009, the commissioner may adjust the

16.1 rates for each service affected by rate changes
 16.2 under this section in such a manner across
 16.3 the fiscal year to achieve the necessary cost
 16.4 savings and minimize disruption to service
 16.5 providers, notwithstanding the requirements
 16.6 of Laws 2007, chapter 147, article 7, section
 16.7 71.

16.8 **(d) General Assistance Medical Care Grants** -0- (6,971,000)

16.9 **(e) Other Health Care Grants** -0- (17,000)

16.10 **MinnesotaCare Outreach Grants Special**
 16.11 **Revenue Account.** The balance in the
 16.12 MinnesotaCare outreach grants special
 16.13 revenue account on July 1, 2009, estimated
 16.14 to be \$900,000, must be transferred to the
 16.15 general fund.

16.16 **Grants Reduction.** Effective July 1, 2008,
 16.17 base level funding for nonforecast, general
 16.18 fund health care grants issued under this
 16.19 paragraph shall be reduced by 1.8 percent at
 16.20 the allotment level.