11/31/94

IN THE MATTER OF THE PROPOSED ADOPTION OF DEPARTMENT OF HUMAN SERVICES RULES GOVERNING DEPARTMENT HEALTH CARE PROGRAM PARTICIPATION REQUIREMENTS FOR PROVIDERS AND HEALTH MAINTENANCE ORGANIZATIONS, MINNESOTA RULES, PARTS 9505.5200 TO 9505.5240

MINNESOTA DEPARTMENT OF HUMAN SERVICES

STATEMENT OF NEED AND REASONABLENESS

INTRODUCTION

The proposed rule is authorized by Minnesota Statutes, §256B.0644, which requires vendors of medical care and health maintenance organizations (hereinafter, HMOs) to participate as a provider or contractor in the medical assistance, general assistance medical care and MinnesotaCare programs (hereinafter "department health care programs") in order to participate in other specified state health insurance plans. Providers other than HMOs must either accept new patients covered under the department health care programs, or department health care programs must be the primary source of coverage for at least 20 percent of the provider's patients. The commissioner of human services must establish participation requirements for HMOs and provide quarterly lists of participating providers to the commissioners of Commerce, Employee Relations, and Labor & Industry. These commissioners in turn must develop and implement procedures to exclude nonparticipating providers from the programs under their jurisdiction.

Minnesota Rules, parts 9505.5200 to 9505.5240 establish requirements for participation by providers and HMOs in the department health care programs.

HISTORY

Minnesota Statutes, §256B.0644 was first enacted in 1992. Its purpose was to provide adequate access to health care for persons whose health care is publicly funded (i.e. under medical assistance, general assistance medical care, or MinnesotaCare) by requiring that health care providers participating in some of the more lucrative state-funded health care programs also participate in those that may be less lucrative. The statute required vendors of medical care and HMOs to participate as a provider or contractor in medical assistance (hereinafter "MA"), general assistance medical care (hereinafter, GAMC) and the "health right plan" (now MinnesotaCare) as a condition of participating as a provider in health insurance plans or contractor for state employees established under Minnesota Statutes, section 43A.18; the public employees insurance plan (PEIP) under Minnesota Statutes, §43A.316; the workers' compensation system under Minnesota Statutes, section 176.135; and insurance plans through the Minnesota comprehensive health association (MCHA) under Minnesota Statutes, §62E.01 to 62E.16.

The statute was amended in 1993, adding health insurance plans for city, county and school district employees to the list from which providers and HMOs might be excluded; this provision does not apply in geographic areas where provider participation is limited by department managed care contracts. Also, language was added clarifying that, for providers other than HMOs, accepting

new medical assistance patients means "... the provider accepts new medical assistance, general assistance medical care, and MinnesotaCare patients...." The commissioner of employee relations was also directed to implement the statute through contracts with participating health and dental carriers. (Laws 1993, chapter 345, article 9, section 14.)

On June 29, 1992 at 16 *State Register* 2992, the Department published a Notice of Solicitation of Outside Information or Opinions.

An Advisory Committee met to discuss concepts and draft language on July 20, 1992; September 24, 1992; and August 30, 1993. Membership of the Advisory Committee can be found in Attachment #1. Rule drafts were mailed to committee members for comments and suggestions. The language of the proposed rule reflects input received from the committee.

SPECIFIC RULE PROVISIONS

The above-entitled rule is affirmatively presented by the Department in the following narrative in accordance with the provisions of the Minnesota Administrative Procedure Act, Minnesota Statutes, chapter 14, and the rules of the Attorney General's Office.

9505.5200 PURPOSE.

This part is necessary to establish the scope and content of the proposed rule. It is reasonable to inform affected persons, providers, HMOs, and the general public of the rule's scope and purpose, that is, to implement Minnesota Statutes, section 256B.0644.

9505.5210 DEFINITIONS.

Subpart 1. **Applicability.** This subpart is necessary to inform anyone reading the rule that certain terms used in the rule have the specific meanings given them in this part. It is reasonable to clarify that the defined terms have a meaning specific to the rule regardless of other possible interpretations and have the same defined meaning throughout the rule.

Subpart 2. **Capitation rate.** This subpart is necessary to explain a particular method of reimbursement used by the department. It is reasonable to use the definition of "capitation" used in part 9500.1451, subpart 4, the department's rule governing administration of the prepaid MA program, because the same payment method is intended. Use of the same definition promotes consistency among rules and reduces confusion.

Subpart 3. **Commissioner.** It is necessary to define "commissioner" as it is used throughout the rule. It is reasonable to use a definition identical or similar to definitions in many current department rules to avoid confusion and promote consistency. (See parts 9500.1451, subpart 4b, prepaid MA program;

9505.0015, subpart 9, MA eligibility; 9505.0175, subpart 5, MA payments; and 9506.0010, subpart 7, emergency rule governing MinnesotaCare.) It is reasonable to include the commissioner's designated representative because the commissioner cannot perform all the tasks for which she is responsible and which are therefore routinely delegated to another.

Subpart 4. **Department.** It is necessary to define this term as it is used throughout the rule. It is reasonable to use the definition already found in many department rules, including parts 9505.0015, subpart 12 (MA eligibility); 9505.0175, subpart 8 (MA payments); and 9506.0010, subpart 10 (emergency rule governing MinnesotaCare), to avoid confusion and promote consistency.

Subpart 5. **Department health care programs.** It is necessary to define these programs as the rule governs requirements for participation in the three programs, mandated under Minnesota Statutes, §256B.0644 (MA, general assistance medical care and MinnesotaCare). The three programs are referred to throughout the rule, and it is reasonable to combine them into one term for the sake of rule clarity and simplicity. It is reasonable to term them "department health care programs" because these are the health care programs administered by the Department of Human Services.

Subpart 6. **Fee-for-service system.** This subpart is necessary to explain a particular method of reimbursement for health services used by the department and to distinguish this method from the capitation rate method. This definition is reasonable because it describes the method of reimbursement for health services for persons covered by department health care programs under which provider payment is based on an established rate structure that determines fees according to the type of service provided.

Subpart 7. **General assistance medical care.** This definition is necessary because GAMC is one of the programs in which participation is required by Minnesota Statutes, section 256B.0644. It is reasonable, for accuracy and completeness, to cite the statutory definition of the program.

Subpart 8. **Geographic area.** This definition is necessary because, under the proposed rule, an HMO will fulfill its participation requirements by contracting as a health plan in specific geographic areas within which it is licensed to operate. Defining geographic area in terms of a county is reasonable because the department does business through counties, i.e., the human services system in Minnesota is a state-supervised, county-operated system. Further, counties are responsible for determining eligibility for department health care programs and for enrolling eligible recipients. Defining geographic area in terms of a portion of a county or multiple county regions is reasonable because the department needs flexibility to contract for specific health service areas, which could be counties, portions of counties, or multiple regions.

Subpart 9. **Health services.** This definition is necessary because the rule frequently refers to the health-related goods and services provided under MA, GAMC and MinnesotaCare. It is reasonable to define and use a single term, similar to the definitions in other department rules (see part 9500.1451,

subpart 8, the prepaid MA program rule and part 9505.0175, subpart 14, the MA rule) for the sake of rule clarity and simplicity and to reduce confusion among rules.

Subpart 10. **Health maintenance organization or HMO.** This definition is necessary because the rule governs HMO participation in department health care programs as well as continuing participation in other state health plans. It is reasonable, for the sake of accuracy and completeness, to define the term by citing the statutory definition of health maintenance organization (a nonprofit corporation or local government unit providing or arranging for health maintenance services).

Subpart 11. **Health plan.** This definition is necessary because organizations other than HMOs are currently eligible to serve medical assistance recipients under a prepaid contract in some areas of the state. Because HMOs will be providing health services to recipients under the same arrangement (i.e. prepaid contract), and possibly in the same geographic areas, it is reasonable, for rule clarity and brevity, to use a single term to refer to both and to distinguish these organizations from individual providers. Further, the rule provides special participation requirements for HMOs in geographic areas where other health plans exist (see part 9505.5230, subpart 6). The definition is consistent with the definition of "health plan" in part 9500.1451, subp. 7a, the prepaid medical assistance program rule.

Subpart 12. **Medical assistance.** This definition is necessary because medical assistance is one of the health care programs in which participation is required under Minnesota Statutes, section 256B.0644. It is reasonable, for accuracy and completeness, to define the term by referencing state and federal law governing the program. This same definition is used in other department rules (see parts 9500.1451, subpart 13; 9505.0015, subpart 31; 9505.0175, subpart 24; 9505.2395, subpart 29; 9505.3015, subpart 27; 9505.3510, subpart 30; 9505.5005, subpart 12).

Subpart 13. **MinnesotaCare.** This definition is necessary because "MinnesotaCare" is one of the department's health care programs in which participation is required under Minnesota Statutes, section 256B.0644. It is reasonable, for accuracy and completeness, to define MinnesotaCare by referencing the statute authorizing the program.

Subpart 14. **Other state health care programs.** This subpart is necessary to identify the state health care programs from which vendors and HMOs may be excluded upon failure to participate in MA, GAMC, and MinnesotaCare. The definition is reasonable because it includes the insurance plans or programs listed in Minnesota Statutes, section 256B.0644. It is reasonable, for the sake of rule brevity and clarity, to identify these programs under one term because the programs are referenced together throughout the rule and "other state health care programs" is consistent with statutory terminology.

Subpart 15. **Prepaid contract.** It is necessary to define this term because it is one of the reimbursement methods used to pay for health services for recipients covered by department health care programs. The definition is

reasonable because it is similar to the statutory definition of "prepaid health plan" for medical assistance (Minnesota Statutes, section 256B.02, subd. 13), including the elements of capitation payment and contract with the department.

Subpart 16. **Provider.** It is necessary to define this term as it is used in Minnesota Statutes, section 256B.0644 to identify the persons or entities that must participate in MA, GAMC, and MinnesotaCare. The statute requires a "vendor of medical care" to participate as a "provider" in MA, GAMC, and Minnesota Care in order to participate in other state health care programs. It is reasonable to use the definition of "provider" set out in the medical assistance rule (part 9505.0175, subpart. 38; see also part 9500.1451, subpart 15, the prepaid MA program rule). This definition is consistent with 42 CFR section 400.203, which states, "Provider means any individual or entity furnishing Medicaid services under a provider agreement with the Medicaid agency."

Subpart 17. **Recipient.** This subpart is necessary to identify the persons receiving health services from providers and HMOs under department health care programs. It is reasonable to use language similar to that in existing medical assistance rules, for the sake of consistency and clarity (see parts 9500.1451, subpart 17, prepaid MA program; 9505.0015, subpart 41, MA eligibility; and 9505.0175, subpart 41, MA payments). It is reasonable to use "recipient" in this rule to refer to persons eligible for MinnesotaCare, even though the MinnesotaCare statute uses the term "enrollees", to distinguish persons covered by department health care programs from persons not covered by those programs.

Subpart 18. **Vendor.** It is necessary to define vendor because it is a term used in Minnesota Statutes, section 256B.0644, distinct from "provider." It is reasonable, for rule clarity and brevity, to reference the statutory definition that is cited in section 256B.0644.

9505.5220 CONDITIONS OF PARTICIPATION; VENDOR OTHER THAN HEALTH MAINTENANCE ORGANIZATION.

Subpart 1. **Required participation.**

Under Minnesota Statutes, §256B.0644, vendors of medical care must participate as providers or contractors in medical assistance, general assistance medical care, and MinnesotaCare in order to participate as a provider in health insurance plans or contractor for public employees, workers' compensation, and the Minnesota comprehensive health association. The statute further defines provider participation as meaning the provider accepts new patients who are recipients, or at least 20 percent of the provider's patients are covered by department health care programs as their primary source of coverage.

In other words, a provider must maintain "an open door," accepting new

patients who are covered under the department health care programs. However, if at least 20 percent of a provider's patients are recipients, the provider is not required to maintain the "open door" and may refuse to accept new patients who are recipients. The statute does not require that a provider actually have a patient caseload of at least 20 percent recipients; however, if a provider's patient caseload is under the 20 percent threshold, the provider must maintain the "open door."

This subpart is necessary to state in rule the statutory participation requirements for providers. This subpart is also necessary to distinguish provider participation requirements from those applicable to health maintenance organizations because Minnesota Statutes, section 256B.0644 treats the two separately.

Item A. Item A is reasonable because it states the basic provider participation requirement using the language in Minnesota Statutes, section 256B.0644. This rule defines "provider" as a vendor that has signed an approved agreement with the department (part 9505.5210, subp. 16); therefore, "participate as a provider" means a vendor has enrolled with the department to provide health care under department health care programs.

Item B. Minnesota Statutes, §256B.0644 states that participation by providers other than HMOs means that providers accept new MA, GAMC, or MinnesotaCare patients or at least 20 percent of the provider's patients are covered by those programs as their primary source of coverage. It is reasonable to implement the statutory requirement by stating that continuous acceptance of recipients as patients is required, except as otherwise provided under the rule subpart dealing with the 20 percent threshold (subp. 3) or under the waiver provision in subpart 4.

It is reasonable to require "continuous" acceptance and application of the same acceptance criteria to new recipients as to other new patients. These requirements ensure providers keep their doors open to recipients until their participation requirements have been met. Further, this is already required of medical assistance providers under part 9505.0195, subpart 10 (governing provider participation in medical assistance), which states:

> A provider shall not place restrictions or criteria on the services it will make available, the type of health conditions it will accept, or the persons it will accept for care or treatment, unless the provider applies those restrictions or criteria to all individuals seeking the provider's services. A provider shall render to recipients services of the same scope and quality as would be provided to the general public. Furthermore, a provider who has such restrictions or criteria shall disclose the restrictions or criteria to the department so the department can determine whether the provider complies with the requirements of this subpart.

Subpart 2. **Exclusion from other state health care programs.**

This subpart is necessary to state in rule the statutory exclusion from participation in insurance plans for state and local public employees, the workers' compensation program, and the Minnesota comprehensive health association for nonparticipating vendors.

Item A. Even though the procedures for excluding vendors from other state health care programs is statutorily assigned to the commissioners of employee relations, labor and industry, and commerce, it is reasonable to state the exclusion in this rule to assure that persons consulting the rule are aware of the penalty for nonparticipation in the department health care programs. It is reasonable to state the exception for local government employee insurance plan vendors in geographic areas where provider participation is limited due to managed care contracts with the department, as this exception was added to the statute in 1993.

Item B. It is reasonable to except from this rule part vendors who are health plan employees or contractors who would not ordinarily enroll as individual providers, but who are requested by the department to enroll individually on a fee-for-service basis to ensure continuity of care for a medical assistance recipient temporarily ineligible for the HMO. This situation occurs occasionally. This exception is reasonable because it clarifies and reassures those vendors not otherwise individually responsible for compliance with the participation requirements (rather, their health plan must comply with participation requirements) that they will not be listed as excluded providers. This item was requested by affected vendors.

Subpart 3. **Limiting acceptance of recipients; 20 percent threshold.**

Minnesota Statutes, §256B.0644, provides that providers other than HMOs satisfy participation requirements if the provider either 1) accepts new MA, GAMC, or MinnesotaCare patients or 2) at least 20 percent of the provider's patients are covered by department health care programs as their primary source of coverage. This subpart is necessary to define how the 20 percent figure is to be determined, and how and when providers may limit acceptance of new patients once the 20 percent threshold is reached.

This subpart allows a provider to determine annually the percentage of patients who are recipients by calculating "active patient caseload" during the provider's most recent fiscal year. If the provider determines that at least 20 percent of the "active patient caseload" are recipients, the provider may refuse to accept new patients who are recipients for the remainder of the fiscal year in which the calculation is made. However, the provider must notify the department that the provider is "closing the door" and must maintain the 20 percent recipient threshold. The provider must "re-open" the door in the next fiscal year unless another active patient caseload is calculated and the 20 percent recipient threshold is met.

Item A. It is reasonable to use an annual calculation to determine whether at least 20 percent of a provider's patients are recipients. Because an

individual provider's caseload as well as the percentage of that caseload covered by department health care programs, may change throughout the year, some commentors suggested a continuous or daily or weekly calculation. However, the Advisory Committee strongly recommended, and the department agrees, that it would be unreasonable to require providers to compute and report this complex number whenever a change occurred. An annual computation linked with the provider's fiscal year avoids undue paperwork and administrative costs for both the provider and the department while still achieving the statutory goal of ensuring access to health services for recipients.

It is reasonable to use "patient encounters that result in a billing" to determine active patient caseload, in the interest of fairness to providers. Many recipients require more health care services and time than patients covered under other insurance plans and thus are more expensive to serve. Basing the calculation on billing encounters, as opposed to simple patient numbers, is an attempt to even out the greater costs of serving persons likely to be greater users of health care services. Further, this eliminates superficial or brief patient contacts, such as picking up a prescription, and ensures that a patient contact actually constituting a health service, as evidenced by a billing, occurred. This was a recommendation of the Advisory Committee.

Item B. Under the medical assistance program, a provider submits bills to the department for payment under a unique provider number assigned by the department. Use of the department provider number will be used to calculate whether the 20 percent threshold has been reached. A clinic, for example, must determine whether 20 percent of its billing encounters are billed under its assigned department provider number; an individual provider must determine whether 20 percent of his or her billing encounters are under his or her individual provider number.

Permitting providers to count patient encounters from all service sites enrolled under the provider's number allows clinics to meet the participation requirement in total (under the clinic's single provider number) rather than individually. This is reasonable, since a clinic site in a location where there is a high concentration of recipients may have 50 percent or more participation, while other sites may have negligible participation. Allowing the 20 percent threshold to be computed across all sites encourages individual sites to continue at greater than 20 percent participation, thereby protecting local access for recipients.

A patient may visit a clinic on a given day, and be sent to one or more clinic locations for services such as x-rays, blood tests, etc. Since these services occur during the same visit, it is reasonable and appropriate to count the various services as a single patient encounter. This simplifies the provider's count of patient encounters as well.

It is reasonable to allow providers to count recipients whose costs are covered under either a fee-for-service arrangement or a prepaid contract, since both are billings resulting from patient encounters and the department uses both methods to reimburse for health services provided under the

department health care programs. Stating this in rule ensures providers are aware that a billing encounter reimbursed under either method may be included in the active patient caseload computation.

Item C allows providers whose annual active patient caseload is at least 20 percent recipients to refuse to accept new recipients as patients. This is reasonable because it is consistent with Minnesota Statutes, section 256B.0644.

The Advisory Committee and commentors have discussed this item at length. Some commentors were concerned that permitting a year between caseload determinations might allow some providers to avoid the participation requirement by meeting the threshold at the point of calculation and then falling below for the rest of the year. On the other hand, the patient composition of some practices may change almost daily; it would be an administrative nightmare for both providers and the department to require a new calculation whenever the patient composition changes. Since providers must determine active patient caseload for a fiscal year, it is reasonable to permit restrictions on accepting new recipients for a fiscal year, i.e., until the next active patient caseload count is completed. Allowing providers to "close the door" for the remainder of the fiscal year after an active patient caseload determination, as long as the 20 percent statutory threshold is maintained, is a reasonable way to minimize administrative costs while achieving the statutory goal of access to health services for recipients.

Item D. It is reasonable to require providers to notify the Department when recipient acceptance restrictions will be in effect. The Department must maintain accurate records to enforce both statute and rule and to fulfill its statutory responsibility to provide a list of participating providers to the commissioners of employee relations, commerce, and labor and industry. Requiring notice in writing ten days before the "closed door" is in effect is reasonable to allow the department to verify if any questions are raised. Requiring sufficient information to verify compliance is reasonable to assist the department in its enforcement responsibilities. Item D does not unduly burden providers, who will have compiled the data as part of their active patient caseload determination.

Subpart 4. Waiver.

Certain conditions may exist which prevent a vendor of medical care from meeting the requirements for participation as a provider in department health care programs. This subpart is necessary to provide for a waiver from the rule requirements in those situations, so that a vendor may not be excluded from the other state health care programs through no fault of the vendor. This subpart is reasonable because Minnesota Statutes, section 14.05, subd. 4 explicitly grants authority to an agency to grant a variance to a rule.

It is reasonable to require a vendor to apply annually for a waiver to ensure timely oversight and accurate recordkeeping by the department.

Item A. If a vendor's practice is full, and no new patients are being

enrolled, it is reasonable to allow the vendor to close enrollment to recipients as well. In this case, by limiting acceptance of all potential patients, the vendor is "using the same acceptance criteria" for recipients as for other new patients, as required in Subpart 1, Item B. Further, it would be unreasonable to required a vendor whose practice is full to accept more new patients, recipients or not, than the vendor can adequately serve.

Item B. Some vendors are ineligible to enroll as providers in department health care programs because the vendor's health care service, when provided by that vendor, is not covered under MA, GAMC, and MinnesotaCare. Examples of vendors ineligible to enroll are acupuncturists and electrolygists. It would be unreasonable to exclude these vendors from the other state health care programs when it is impossible for them to participate in department health care programs through no fault of their own.

9505.5230 CONDITIONS OF PARTICIPATION; HEALTH MAINTENANCE ORGANIZATION.

Subpart 1. **Participation in department health care programs.** Minnesota Statutes, section 256B.0644 specifically requires the commissioner of human services to establish requirements for participation in department health care programs by health maintenance organizations. This subpart is necessary to comply with the statutory mandate and to establish those requirements.

In summary, this subpart requires HMO participation in each of the three publicly-funded health care programs administered by the department by requiring HMOs to respond to department requests-for-proposals to contract as a health plan in geographic areas where the HMO is licensed to operate and does not meet the participation threshold.

This requirement is necessary and reasonable to provide adequate access to and continuity of health care for recipients. Some families and individuals may be eligible for different programs at different times; or, different members of one family may be eligible for different programs (e.g. children eligible for MA while parents are eligible for GAMC). Requiring HMOs to submit a proposal to contract for all three department programs assures that family members may receive health care from the same health plan, and families and individuals can continue to use the same providers even when program eligibility changes.

In addition, the department must present to the legislature in February, 1994, a plan to integrate MA, GAMC, and MinnesotaCAre into one program. It is therefore reasonable to require that HMOs participate in all three programs, as they will be a single program in the future.

This requirement is reasonable as well because it assures continuity of recipient enrollment for HMOs while providing that HMOs participating in the more lucrative state health care programs participate in those that are less profitable.

It is reasonable to state that HMO participation in department health care programs is required only within their approved service areas. (Approved service areas are the geographic areas in which an HMO is licensed by the Minnesota Department of Health to sell its products under Minn. Rules, part 4685.1010, subp. 1, item B.) This rule does not require an HMO to operate in an area where it has not been licensed to operate by the Department of Health.

This provision is reasonable as well because it addresses the concerns of HMOs that there are areas of the state where they do not have adequate access to a network of providers and/or where local providers choose not to contract with HMOs. Stating that participation is required only in approved service areas reassures HMOs that they will not have to meet participation requirements in areas where it would be impossible and impractical.

Item A. In February, 1993, the department presented to the legislature, as required under Laws 1992, chapter 549, a managed health care delivery plan for recipients of department health care programs. The plan expands managed care programs from the current four counties (Hennepin, Dakota, Itasca, and Ramsey) to other parts of the state where large numbers of department health care program recipients live and HMO service areas exist. The plan identified ten counties into which managed care programs would expand through 1995. It was approved by the legislature, and department staff initiated a planning process for the expansion. The department will be developing plans for the future statewide expansion of managed care, which will be presented to the legislature for approval.

A crucial step in the process which the department follows to expand and/or continue managed care programs is the issuance of a request for proposals for prepaid health plans or HMOs to contract with the department to provide health services in a geographic area. HMOs respond to the request for proposals by submitting a detailed proposal that describes how the HMO complies with department specifications, including a description of its complete service network in the geographic area.

As the managed care programs expand to new counties or geographic areas, this rule part allows the department to require HMOs to submit a response to department requests for proposals to participate in managed care. It is reasonable to define participation as the submission of a proposal rather than execution of a contract as a health plan, as the department may need to reject proposals, e.g. proposals that do not fully meet department standards or which present redundant provider networks. Further, this also allows the department needed flexibility in establishing managed care, i.e. flexibility to require HMOs to submit a response to a request-for-proposals in areas of the state where health plan contracting allows the best access to health care, while not obligating the department to contract with HMOs when a prepaid health plan would not be efficient or the HMO network would not be adequate to serve the needs of recipients.

At the same time, this item does not unreasonably exclude an HMO from the other state health care programs in areas where the HMO is not under contract with the department as a health plan for reasons unrelated to recipient enrollment. It is necessary to guarantee that, when local circumstances

dictate and the state engages in strategies for providing managed care other than contracting with HMOs, HMOs will not be required to participate in the department health care programs or face exclusion from the other state health care programs.

This item is reasonable as well because HMOs outside service areas designated in a request for proposals are not required to respond, thus allowing them to remain in compliance with this rule.

Subitem 1 requires an HMO that is licensed in the identified service area but does not have a specified proportion of recipient enrollees to submit a response to a department request for proposals to contract as a health plan. This requirement is a reasonable interpretation of the legislative intent under Minnesota Statutes, section 256B.0644, that providers and HMOs participating in public employee health plans also provide services to recipients of MA, GAMC, and MinnesotaCare. (See also the discussion under subpart 3.)

Subitem 2 requires HMOs presently providing health services to recipients in an area where enrollment in a health plan is mandatory to respond to department requests-for-proposals for that area. This requirement is reasonable because it ensures continuity of care to recipients currently in mandatory programs, who will not be forced to change providers because their HMO would not continue to contract as a health plan. This requirement also serves to assure continuing compliance by HMOs currently under contract with the department.

It is reasonable to describe a mandatory program, as it is utilized by the department to expand managed care. In the past the department has operated both mandatory and voluntary managed care programs. The mandatory approach has been more successful in reducing the risk of adverse selection (excessive selection of a particular health plan or vendor by individuals who are relatively "sicker" or have greater need of health care services and therefore require relatively more frequent or more expensive health care) of health plans over the fee-for-service system. When a voluntary HMO managed care program exists, if access is greater through the health plan model individuals with increased medical needs tend to enroll in the health plans to assure access to care. This increases the financial risk for the health plan if not balanced by a number of enrollees with lesser medical needs. For example, some health plans experience adverse selection by pregnant women who enroll in health plans in order to assure their access to obstetrical services.

In addition to addressing adverse selection issues, a mandatory program helps assure that the population base is large enough to allow each HMO contractor a reasonable market share of enrollment. Further, a mandatory program reduces state and county administrative requirements by reducing the ability of recipients to change enrollment.

Item B. It is reasonable to require that the response to a request for proposals meet the specifications in the department's request, to assure that an HMO does not evade participation requirements by simply submitting a response that is rejected because it does not meet department specifications.

This requirement also assures that HMOs proposing to contract for department health care programs will be able to provide required services because their response must demonstrate how the HMO will meet the specifications in the department's request-for-proposals.

Item C. It is reasonable to provide in rule that the commissioner will notify affected HMOs if a response will be required to a department request-for-proposals to contract as a health plan. This item was requested by the Advisory Committee and assures that HMOs are aware of their responsibilities under this rule.

Subpart 2. **Exclusion from other state health care programs.**

This subpart is necessary to state in rule the statutory prohibition against contracting to provide services under insurance plans for state and local public employees, workers' compensation program, or the Minnesota comprehensive health association. It is reasonable to state this exclusion in rule to assure that HMOs and other persons consulting the rule are aware of the penalty for nonparticipation in the department health care programs. Even though the procedures for excluding providers from other state health care programs are statutorily assigned to the commissioners of employee relations, labor and industry, and commerce, it is reasonable to state the exclusion in this rule to assure that persons consulting the rule are aware of the penalty for nonparticipation in the department health care programs.

Subpart 3. **Participation threshold.**

This subpart is necessary to implement the commissioner's statutory mandate to establish participation requirements for HMOs. Participation requirements are needed to assure adequate access to health care services for recipients. This subpart is also necessary to assure continued viability of health plans that provide health services to recipients by assuring that no participating health plan is required to serve an excessive proportion of recipients funded through MA, GAMC, or MinnesotaCare.

It is reasonable to state that the commissioner will determine, prior to issuing a request-for-proposals, whether HMOs in the area are currently serving a specified percentage of recipients and consequently, whether a response to the RFP will be required (see subpart 1, item A, subitem 1). (Recipient enrollment information is available to the commissioner in the month before a request-for-proposals would be issued, because the department prepays HMOs monthly for recipient health services.) If the HMO has met its participation threshold, no response will be required, thus saving the HMO time and money should it choose not to submit a response. This also allows the department to prospectively determine whether there will be a minimum response to the request-for-proposals.

Items A to C. The formula set forth permits an HMO to limit its overall participation in department health care programs to a proportion of total recipient enrollees equal to the HMO's proportion of HMO enrollment statewide. This is reasonable because it attempts to equalize HMO participation across

the state and establishes a consistent process by which every HMO's enrollment is measured. Further, the formula makes use of an established reporting procedure and easily accessible data, avoiding additional data collection and reporting by the HMOs. The formula relies on HMO enrollment numbers contained in the annual Department of Health HMO report as well as the monthly recipient enrollment figure prepared by the Department of Human Services. It is reasonable to state in rule where the data is available, to ensure its accessibility to interested parties.

It is reasonable to include the estimated number of recipients anticipated to enroll in the geographic area in the denominator of the recipient ratio (C/D): The department will specify in the request-for proposals the number of recipients in the geographic area expected to enroll in HMOs. If this number were not included in the formula, an individual HMO's market share of recipients would be skewed to indicate a higher participation threshold than will be the case once the health plan begins operating in that area.

Subpart 4. **HMO subcontracts with other HMOs.**
This subpart is necessary to assure adequate access to health care services for recipients in all areas of the state. It is reasonable to allow only one HMO in a subcontracting arrangement to count recipients, to ensure a sufficient number of HMOs contract as health plans in all areas of the state. If subcontracting HMOs counted the same recipients, duplicate counting would occur. Duplicate counting could reduce the department's ability to develop health plans because it would be easier for each HMO to meet its participation threshold without actually increasing the number of recipients receiving services; and, there would be no incentive for HMOs to expand into additional areas.

The department's concerns are: (1) which HMO "counts" the enrollees and not how the contractor and subcontractor came to this decision, and (2) providing HMO's the flexibility to make business decisions without excessive governmental interference; therefore, allowing the HMOs involved to decide which HMO may count the recipients is reasonable.

Subpart 5. **Licensed health maintenance organization that is a controlling organization.**

This subpart is necessary to clarify in rule how related health maintenance organizations count recipients for purposes of meeting their participation threshold. This subpart is reasonable because permitting a controlling organization to count all recipients served by related HMOs is conducive to administrative efficiency and recipient access to a wider network of health care providers. This subpart was requested by health maintenance organizations. The department agreed with the recommendation because individual HMO computations would mean the department entering into multiple contracts with each related HMO; the result would be more paperwork and monitoring activity without necessarily improving access to services for recipients. Further, the controlling organization may offer a wider network of providers, and better access, than the individual HMOs.

Subpart 6. **Other enrollment limitation.**

This subpart is necessary to ensure access to health services and a choice of providers for recipients, as required under Minnesota Statutes, section 256B.01 (requiring a free choice of vendors for medical assistance recipients) and under the federal waiver authorizing Minnesota to require medical assistance recipients to enroll in managed care programs.

This subpart was the subject of much discussion between the department and health maintenance organizations. Permitting HMOs in an area where there are three or more health plans to limit recipient enrollment at 55 percent is reasonable because it assures compliance with state and federal choice requirements and protects recipient access to services.

The department first considered prohibiting any restriction on percentage of recipient enrollment; however, the department would then have to negotiate individual percentage limits in its contracts with each health plan in a geographic area and might not be able to ensure access and choice to all recipients.

The department also considered setting a proportional limitation, i.e. when there are three plans in an area, each must serve one-third of recipients living in the area. However, to comply with state and federal choice requirements (i.e. ensure a recipient has a choice of at least two HMOs), HMOs must be required to serve at least 50 percent of area recipients: if, for example, two HMOs each reached a limit of less than 50 percent of area recipients and stopped enrollment, all new recipients in the area would have no choice but to join the remaining HMO. If recipients are left with only one HMO option, the department would be out of compliance with the terms of federal waivers.

The 55 percent threshold allows HMOs some outside limit on recipient enrollment; otherwise, their proportion of enrolled recipients could far exceed the 55 percent threshold. Health plans are required to accept any enrollee who chooses that plan; neither the department nor the health plan has control over which recipient chooses which plan. The 55 percent limit assures that there will be some outside limitation on enrollment for individual HMOs as well as a choice of at least two health plans for recipients.

This item is also reasonable in that its end result is that no one health plan can achieve a monopoly on department business within a geographic area. This affords the department greater flexibility when negotiating health plan contracts and encourages competition among plans, which is conducive to better health services at lower cost.

Subpart 7. **Contracting as a health plan.**

This subpart is necessary to ensure that HMOs that contract for department health care programs are qualified to provide all health care services specified in the department's request for proposals.

It is reasonable to allow an HMO, when it first contracts as a health plan in an area, to provide recipients a network of health care providers that is not identical to the network offered state employees, corporate purchasers of HMO services, and medicare HMO enrollees. HMOs report that, when contracting in a new geographic area, they are concerned about contracting with the most efficient and trustworthy providers in order to minimize risk. In some areas HMOs will be serving recipients for the first time, and they prefer contracting with providers experienced in serving the recipient population. Providers may choose not to contract with a given HMO to serve recipients, thus precluding the HMO from offering the same network.

Further, HMOs under contract to serve recipients must also comply with Minnesota Statutes, section 256B.031, subd. 10, paragraph (b), which requires subcontracts with community clinics and public health agencies. Because these subcontracts are not required for other state health care programs, it is reasonable to permit an HMO network for recipients that is not identical. Permitting HMOs to offer recipients a provider network different from that offered other populations during the initial contract period addresses those concerns.

At the same time, if recipient access to services should be threatened, the department will request the HMO to increase its provider network. Past experience demonstrates that HMOs have been flexible in such situations and have increased their network as needed to meet recipient access needs.

9505.5250 **REPORTS; EXCLUSION FROM PARTICIPATION.**

Subpart 1. **Quarterly reports to state agencies.** Minnesota Statutes, section 256B.0644, requires the Department to "provide lists of participating medical assistance providers on a quarterly basis to the commissioner of employee relations, the commissioner of labor and industry, and the commissioner of commerce." This subpart is necessary to establish in rule the procedures for compliance with the statutory reporting requirment.

Filing an annual "master" report on April 1st of each year is reasonable because an April 1st deadline allows time for collection and verification of data for the preceding calendar year. An April master report also allows sufficient notice to the commissioners of commerce, employee relations, and labor and industry if changes must be made in those agencies' contracts with health plans. Quarterly amendments ensure that the mandated list of participating providers and HMOs is current. It is reasonable to publish notice of the availability of the current report in the State Register, so that interested parties can obtain the information in the reports.

Subpart 2. **Notice of noncompliance.**

Minnesota Statutes, §256B.0644 requires the commissioners of employee relations, labor and industry, and commerce to develop procedures to exclude as participating providers in the program or programs under their jurisdiction

those providers or HMOs that do not participate in the medical assistance program.

This subpart is necessary to establish a process whereby providers and HMOs that apparently have failed to comply with the participation requirements, and are subject to exclusion, can demonstrate compliance. This is necessary to ensure the continued viability of these entities and to ensure continued adequate access to health care services (i.e., the most choices of providers and HMOs) for recipients.

It is reasonable to provide written notice of alleged noncompliance because of the potentially severe consequences. Providing an opportunity to demonstrate compliance within 30 days is reasonable because this period of time is sufficient to compile evidence of compliance (such as data showing compliance with participation percentages or evidence of an "open door" to recipients) while assuring that the commissioner may act in a timely manner. In turn, this prevents providers and HMOs erroneously reported as out of compliance from being excluded from participation in the other state health care programs.

Subpart 3. **Exclusion for noncompliance.**

This subpart is necessary to implement the mandate in Minnesota Statutes, §256B.0644 to exclude nonparticipating providers and HMOs from participation in the other state health care programs (health insurance plans for public employees, the workers' compensation system, and MCHA).

It is reasonable to ensure that providers and HMOs notified of alleged noncompliance will be notified of the commissioner's final determination within 30 days after submitting evidence of compliance. This provision was added at the request of the Advisory Committee. It is reasonable and consistent with statute that providers and HMOs that fail to demonstrate compliance be removed from the next subsequent report submitted to the commissioners of employee relations, labor and industry, and commerce (the agencies listed in statute that oversee health insurance plans for state employees, the workers' compensation system, PEIP, and MCHA).

Subpart 4. **Reinstatement.** This subpart is necessary to provide a process whereby providers and HMOs excluded from the other state health care programs may be reinstated as participating providers. Minnesota Statutes, section 256B.0644 requires each of the commissioners to develop procedures to exclude providers not participating in department health care programs from the programs under their jurisdiction. Therefore, the procedures for exclusion from other state health care programs are the responsibility of the commissioners of employee relations, labor and industry, and commerce. Minnesota Statutes, section 256B.0644 requires the commissioner of human services to submit a quarterly report of participating providers. Therefore, it is reasonable to simply provide that the commissioner will reinstate on the next quarterly report providers and HMOs that demonstrate renewed compliance

with these rule parts.

SMALL BUSINESS CONSIDERATIONS

In preparing these rules, the Department considered the requirements of Minnesota Statutes, section 14.115 but believes that these rules come within the exemption in section 14.115, subd. 7, clause (3) for providers of medical care. The rule establishes standards for vendors of medical care and health maintenance organizations. Vendors of medical care, as defined in Minnesota Statutes, section 256B.02, subdivision 7, are persons furnishing health care goods and services. Health maintenance organizations, as defined in Minnesota Statutes, section 62D.02, subdivision 4, are organizations that provide comprehensive health maintenance services.

AGRICULTURAL LAND

Because the proposed rule language does not have a direct and substantial adverse impact on agricultural land in Minnesota, Minnesota Statutes, §14.11, subdivision 2 is not applicable.

EXPERT WITNESSES

If this rule is heard in public hearing, the Department does not intend to have outside expert witnesses testify on its behalf.

Dated:

MARIA R. GOMEZ
Commissioner