Minnesota Department of Human Services **Health Care**

Mission Statement

The Department of Human Services, in partnership with the federal government, county and other public, private, and community agencies throughout Minnesota, is a state agency directed by law to assist those citizens whose personal or family resources are not adequate to meet their basic human needs. It is committed to helping them attain the maximum degree of self-sufficiency consistent with their individual capabilities.

To these ends, the Department will promote the dignity, safety, and rights of the individual, and will assure public accountability and trust through responsible use of available resources.

A Report to the 1998 Minnesota Legislature as required by Minnesota Statutes 256B.692 Subdivision 10

Prepaid Medical Assistance Program *and* County Based Purchasing

February 1998

REPORT TO THE LEGISLATURE: PREPAID MEDICAL ASSISTANCE PROGRAM AND COUNTY BASED PURCHASING

Minnesota Statutes 256B.692 Subdivision 10

February 1998

MINNESOTA DEPARTMENT OF HUMAN SERVICES

Cost of completing this report:

Minnesota Statutes, section 3.197, requires the disclosure of the cost of preparing this report.

Staff time: $2,500

Submitted by the Minnesota Department of Human Services

February 1998

Introduction

Minnesota has implemented prepaid health care programs for Medical Assistance (MA) and General Assistance Medical Care (GAMC) since 1984. These programs, commonly referred to as the Prepaid Medical Assistance Program (PMAP), began with a demonstration project in three counties: Dakota, Hennepin and Itasca. Currently, the Department of Human Services (DHS) contracts with eight health plans covering twenty-seven counties.

In 1995, the federal government proposed to establish Medicaid block grants to states. This prompted Minnesota to plan for a rapid statewide expansion of PMAP. While these changes were never implemented, several Minnesota counties expressed concern about the expansion of PMAP and also indicated interest in considering county-based purchasing for state health care programs. DHS, the Minnesota Department of Health (MDH) and the association of Minnesota Counties (AMC) agreed to work together to develop a proposal on health care purchasing that was passed into law in 1997.

This law requires all counties not currently participating in PMAP to begin enrollment of eligible individuals no later than January 1, 1999. All counties, whether currently participating in PMAP or not, are given the authority to choose which type of managed care model will be implemented in their county: PMAP or county-based purchasing (CBP). The law modified PMAP to enhance the county's role in the implementation of the program. The law also established CBP, in which DHS pays the capitation to a county or group of counties, rather than a health plan, to manage the enrollees' care. The law requires any county wishing to implement CBP with enrollment beginning on or before January 1, 1999 to submit a preliminary proposal to DHS by September 1, 1997.

County requirements for implementing managed care for MA and GAMC recipients are prescribed in Minnesota Statutes, Section 256B.69 and Laws of Minnesota, Chapter 203, Article 4, Sections 49 and 56. In addition to the authority to choose whether their MA and GAMC recipients are enrolled in PMAP or CBP, counties are given additional authority in PMAP implementation. Additionally, parameters for county-based purchasing models are prescribed. DHS Bulletin # 97-24-1(attached) contains additional detail about the legislation, as well as the text of the legislation.

"Enhanced" PMAP

Legislation passed in 1995 describes the county board authority with respect to the PMAP program. The law requires the inclusion of the county board in the process of development of the request for proposals (RFP) and in developing a time line that was

mutually agreeable to both the county and the state for PMAP implementation. Additional language regarding involvement in PMAP was added in the 1996 and 1997 legislative sessions. All of these changes give counties a more active role than they had previously in the implementation of PMAP. The implementation time line for each county must now be mutually agreed upon between DHS and the county. The county is actively involved in the development of the RFP and may develop local public health goals for inclusion in the PMAP contracts. Each county reviews all health plan proposals to serve eligible enrollees in the county, and makes recommendations to DHS regarding the number of plans needed to serve the county and which plans should be given contracts. Counties also participate in the contract renewal process, making recommendations whether a contract covering that county should be renewed. A dispute resolution process is available to any PMAP county.

Since the passage of these changes to the county's role in PMAP, DHS has issued two RFPs covering 32 counties. In developing these RFPs, DHS has observed a marked improvement in the RFP development process, the preparation of the proposals, and the implementation of the program as compared with the experience of the original 16 counties. The enhancements allow for greater county input and have resulted in more flexibility on the part of DHS. There is more dialogue between DHS and the county prior to implementation. In many cases, this has resulted in greater county satisfaction with the health plans and with DHS after PMAP is implemented. DHS's increased flexibility has allowed counties more latitude in designing their enrollment and advocacy functions, while maintaining a consistent state-wide standard. There has also been a notable change in the way health plans interact with counties. They begin their communication with counties earlier in the RFP process, and there is increased depth of communication. Productive exchanges between health plans and counties are taking place in the planning stages. The result, in many cases, seems to be fewer post-implementation problems to be resolved. Enhanced PMAP has resulted in new "ownership" by the counties; county officials take increased interest in developing a better understanding of managed care, have been more likely to commit to make it work, and have been more likely to defend the program.

In October 1997, DHS staff began working toward PMAP implementation with 24 new counties that chose not to implement CBP in 1999. An RFP was issued on December 22, 1997, covering 23 of these counties. (Wilkin County was not included due to a scheduling difficulty; it will be included in an RFP to be issued during 1998.) (See attached map.) Health plans must submit responses by February 6, 1998. Enrollment will begin in some of the 23 counties as early as June 1, 1998.

DHS will issue additional RFPs during 1998 as necessary to develop PMAP contracts for counties that do not implement county-based purchasing by January 1, 1999.

County-Based Purchasing

The 1997 legislation allows DHS to make capitated payments to a county or group of counties to manage the care for recipients who would otherwise be enrolled in PMAP. The county must meet the requirements of Minnesota Statutes 62D or 62N, governing health maintenance organizations (HMOs) and community integrated service networks (CISNs), but does not have to obtain a certificate of authority, which means the CBP would have modified solvency and reserve requirements. The CBP entity would directly provide or purchase health care services from providers, care systems, or health plans such as HMOs. The CBP entity must assure choice for the recipients it serves, for example, by contracting with two or more care systems. The CBP entity would be responsible for assuring all medically necessary services covered under PMAP. The county or counties would take all financial risk from DHS; the county or counties may assign some or all of the risk to a third party. The CBP entity would be required to comply with the same appeals requirements that now apply to PMAP contractors. The legislation provides for a dispute resolution process for implementation issues between the counties and the departments.

On July 1, 1997, DHS issued Bulletin # 97-24-1 (attached), which instructs counties wishing to implement CBP on how to submit preliminary proposals. The Association of Minnesota Counties reviewed this bulletin prior to its release. Counties were allowed to prepare their proposals in a work plan format. Counties were informed that their proposals would be evaluated on their substantial demonstration of the county's ability to meet key requirements, including: provider networks, administrative systems, care management, and financial solvency. In August 1997, each of the 87 counties was sent an information packet with detailed information on these key requirements.

By the September 2, 1997 deadline, DHS had received 19 preliminary proposals covering 47 counties. (See attached map.) Six of these proposals involve 11 counties currently participating in PMAP. A team comprised of DHS Purchasing and Service Delivery staff and MDH Managed Care Systems staff reviewed the proposals. The team used a standardized protocol for review to ensure consistency of responses. Due, in part, to the work plan format agreed to by DHS, most of the proposals contained limited detail on the counties' proposed system to provide and manage care. Many counties indicated that the preliminary proposal was not a final decision to participate, and that the county would use the planning process to further evaluate its purchasing options. Generally, the purchasing arrangements being considered by counties can be grouped into three models:

1) county contracts with licensed health plans, 2) county contracts with provider networks, or 3) a hybrid wherein the county contracts with licensed health plans for some services and contracts directly with providers for other services.

Counties opting for CBP are interested in the redesign of the system as it currently exists. Some counties have embraced the option with the intent of changing how health care services are delivered in their region. Other reasons include the need to improve the coordination between acute care services and other services that the county provides and the desire to protect the local health care infrastructure.

None of the preliminary proposals were rejected. DHS and MDH did prepare responses that indicated the tasks, activities and time lines the county would need to complete to position itself to successfully implement CBP in 1999. These tasks, activities and time lines were based on DHS and MDH's experience in contracting with and regulating health plans. DHS sent these responses on November 14, 1997. In December 1997, representatives from DHS and MDH traveled to each county or group of counties to discuss the DHS/MDH response, and to assist the counties in identifying the assistance they would need.

Other resources and forms of assistance are also available to counties. Each proposal has been assigned a DHS development manager, who is responsible for coordinating available resources and assistance within DHS. MDH has hired a full-time staff person to work on CBP. This person is available to any county for questions and assistance in meeting MDH requirements. AMC has broadcast a series of video conferences on the subject of CBP since May 1997. Private consultants have also approached the counties. Several counties have contracted with consultants for a variety of activities. Some of the health plans under contract for PMAP have offered to meet with counties to discuss managed care for MA and GAMC recipients. In addition, based on county requests, DHS scheduled four sessions (one if St. Paul and three video conferences) on quality assurance and data requirements for January and February 1998.

Since the original proposals were received, two counties, Otter Tail and Winona, have formally withdrawn their proposals, choosing instead to implement PMAP in 1999. Five counties in northeastern Minnesota have also voted to delay implementation of CBP until the year 2000. Other counties have also indicated that they are considering a delay to allow additional time to review DHS data and evaluate new service delivery models.

Continuing Issues for CBP

There remain a number of issues that need to be resolved before DHS and the counties can implement CBP. They include:

- **Data.** DHS has made reports available to counties, which are currently used by DHS and health plans to implement PMAP. These reports are available by county, and include current eligibility by program type, expenditures by each type of provider for 1996, expenditures by rate cell, expenditures by service type, and the 1997 rates. This information gives the counties the ability to evaluate the current rates against past experience, identify provider network needs, develop provider rate agreements, and quantify administrative contract requirements. However, counties have expressed the need to have more current data, as well as additional reports in order to make prudent decisions regarding whether to continue to pursue CBP, and in order to be well positioned to negotiate provider agreements. Initially, each county submitted requests to DHS. Some of the information was provided, but not all of the requested information was available. Recently, counties have begun to coordinate their requests. DHS has worked with the consultants hired by AMC to develop additional data for analysis and have agreed to deliver this information in specified formats (see attached table) to AMC on a mutually agreed upon schedule. The data submission will initially include DHS fee-for-service claims. The managed care encounter data will be provided once service validation has been completed. This coordinated approach should provide greater efficiencies for both the counties and DHS.

- **Timing of Implementation.** State law requires implementation of PMAP or CBP by January 1, 1999. Due to the additional time needed to prepare the additional reports noted above, and so that counties may adequately analyze and utilize the data, DHS, MDH and AMC support a proposal to allow qualifying counties to seek a delay of up to nine months in the implementation of CBP. For the 11 counties currently involved in PMAP, delay of implementation of CBP until the year 2000 is already an option. DHS and MDH can support a delay as long as the implementation of CBP occurs in the relatively near future. The state should not forgo the benefits of capitated purchasing unless the county can develop and implement viable alternatives. Delays in implementation will reduce the state's ability to negotiate service expansions, such as drug coverage for Qualified Medicare Beneficiaries, under our waivers with HCFA. Also, the time line for statewide implementation of PMAP/PGAMC has changed several times over the past few years. The uncertainty poses extra challenges for local providers and for the PMAP contractors in preparing to serve MA, GAMC and MinnesotaCare recipients.

- **Final Criteria.** DHS is developing criteria for final CBP proposals, which are due July 1, 1998. DHS maintains that the criteria must allow for the assessment of the county's ability to effectively ensure that appropriate health care services are provided. With that in mind, DHS proposes to rely both on MDH's enforcement of Chapters 62D and 62N, and on using a modified version of the same RFP requirements used for the PMAP health plans. Counties have expressed interest in identifying specific areas of Chapters 62D or 62N, which do not apply or which need to be adapted to address counties as government entities. Also at issue is the type of oversight the state departments should have in ensuring that counties meet the standards in federal and state law. DHS and MDH are proposing the same amount of oversight as implemented for current DHS contractors and providers.

- **Federal Authority.** In mid-1997, DHS held preliminary discussions with the Health Care Financing Agency (HCFA) about CBP. DHS was told that, to the extent that CBP mirrors PMAP, additional waivers would not likely be required, except to identify the applicable counties. However, if a CBP project deviates from the PMAP model, waivers may need to be granted. Because counties are considering a redesign of the system, it is possible that waivers may be necessary. DHS is currently working with AMC to prepare material for HCFA.

- **Contracts or agreements.** At issue is the type of arrangement DHS will use to hold the counties accountable for the provision of health care services. DHS has contracts with the PMAP health plans and has proposed the use of contracts with counties for CBP. The federal government ensures compliance by the State with federal standards through written agreements including the State plan and the federal waivers. Failure to comply with the terms of these documents by the State can result on loss of federal funds. Current law requires that the state contract with entities for provision of medical assistance and GAMC services. However, counties want to evaluate an option that contracts may not be needed since counties already act as government agencies.

- **Enrollment and advocacy.** Several community based groups representing consumers have expressed concern that, unlike PMAP, the advocates in CBP counties have a potential conflict of interest by having the additional responsibilities of being the purchaser and the case manager. DHS will carefully review the proposed advocacy function in CBP counties and require protections against direct conflicts of interest. A work group comprised of DHS, AMC and MDH staff and representatives of MA and GAMC consumers are discussing this issue currently.

- **Rates.** As required by law, DHS intends to pay uniform rates to both PMAP contractors and CBP entities. Counties are interested in modifying the process for setting rates, but have not disagreed with accepting the same capitation as health plans. Typically, PMAP rates are developed by late summer, prior to the next contract year. This allows for adjustment of rates in response to any legislative action. Counties are eager to have final rate information prior to July to determine whether participation in CBP is appropriate.

Conclusions

Although a number of issues remain for DHS, MDH and AMC to resolve, recent changes in PMAP and the introduction of the CBP option have yielded benefits for Medical Assistance and General Assistance Medical Care recipients and Minnesota taxpayers. Some of these benefits include:

- **Greater accountability.** Both enhanced PMAP and CBP give the counties an expanded role in health care services for MA and GAMC recipients that will result in increased accountability of those who deliver health care services. Under enhanced PMAP, the expanded role of the county means that "another set of eyes" will be holding health plans accountable to maintain provider networks that deliver accessible, quality services. The same holds true for those CBP counties that contract with HMOs or CISNs. Local recipients of MA and GAMC services will now be able to hold local decision makers (county commissioners, human service and public health directors) at least partially accountable for the quality of their health services. Under enhanced PMAP, the state is also held more accountable through the inclusion of a dispute resolution process that is now available to counties.

- **Enhancement of local oversight.** Through enhanced PMAP or CBP, those health and human services officials who are closest to the recipients and the providers of services now have a more direct interest in the provision of those services. This local oversight results in the design of networks that are more sensitive to the needs of the local consumers regarding geographical access, cultural considerations, local market preferences and other locally identified issues.

- **Local Solutions.** CBP allows groups of counties to develop models that are specifically designed to address health care issues and concerns that are unique to the area involved. Enhanced PMAP assures that county boards and their staff will have opportunities to surface any such issues in the development of the RFP and the ultimate selection of plans.

- **Greater opportunity to integrate social services.** There is a potential to improve the quality, efficiency and reduce costs of services delivered to MA and GAMC recipients who also use social services through the county agency.

- **More coordinated approach to local public health goals.** Enhanced PMAP provides that counties may recommend language regarding public health goals for inclusion in the PMAP contracts. It is anticipated that this will result in greater coordination of the efforts and resources of the health plans with those of the county public health agency to meet locally identified goals.

- **Heightened competition.** Because counties now have the authority to make recommendations regarding local PMAP contracts, and the authority to implement locally based alternatives to more "traditional" PMAP health plans, health plans now have added competitive pressure to deliver quality products. Similarly, counties choosing CBP must meet the same standards as PMAP providers, and therefore, must provide a standard of care that is at least as effective as would otherwise available through PMAP.

- **Expansion of the paradigm.** The increased discussion among the state, the counties, and the health plans is focusing discussion on ways of serving MA and GAMC recipients that go beyond what was current thinking in the PMAP program.

#97-24-1

Bulletin

Date: July 1, 1997

Minnesota Department of Human Services ■ 444 Lafayette Rd. ■ St. Paul, MN 55155

OF INTEREST TO

- County Commissioners
- County Human Services Directors
- County Community Health Services Administrators
- County Public Health Nursing Directors

ACTION

Please review and decide whether your county will, on January 1, 1999, participate in the Prepaid Medical Assistance Program (PMAP), or implement county-based purchasing of health care services.

DUE DATE

All counties must notify DHS of their decision by September 2, 1997.

Counties Must Choose Managed Care Option for MA and GAMC

TOPIC

Managed care options for purchasing health care for Medical Assistance (MA) recipients and General Assistance Medical Care (GAMC) recipients

PURPOSE

To describe the options for counties in implementing managed health care for MA and GAMC recipients

CONTACT

Questions concerning this bulletin should be directed to:

Counties	Contact	Phone
Aitkin - Faribault	Pam Austin	612/297-2355
Fillmore - Mahnomen	Mary Bruns	612/296-6040
Marshall - Rice	Tom Fields	612/297-7303
Rock - Yellow Medicine	Wally Goettl	612/296-1650

SIGNED

Elaine J. Timmer

ELAINE J. TIMMER
Assistant Commissioner
Health and Continuing Care Strategies

I. Introduction

Legislation passed in 1997 requires all Medical Assistance (MA) and General Assistance Medical Care (GAMC) recipients who are required or who may elect to participate in the Prepaid General Assistance Medical Care Program or the Prepaid Medical Assistance Program (PMAP) to be enrolled in a prepaid managed health care program. All counties not currently participating in PMAP must begin enrollment no later than January 1, 1999. All counties, whether currently participating in PMAP or not, now have the authority to choose which type of managed care model will be implemented in their county: PMAP, or county-based purchasing (CBP).

The purpose of this bulletin is to describe the options available to the counties, and to request counties to notify DHS of their chosen option. It also describes requirements for the new CBP option and requests preliminary proposals from those counties choosing this option.

II. Background

Minnesota's prepaid health care programs for MA and GAMC recipients (PMAP) have been implemented since 1984. At this time, 27 counties are implementing PMAP for MA and GAMC recipients who are not excluded from participation.

Late in 1995, federal government proposals included Medicaid block grants to states with decreased funding. The Department began to plan for statewide expansion of managed care. When the federal government failed to move on any Medicaid block grant proposals, and some Minnesota counties indicated interest in county-based purchasing of health care, it became the impetus for DHS, the Minnesota Department of Health and the Association of Minnesota Counties to agree to the legislation described in this bulletin.

III. Summary of Legislation/Options

County options for implementing managed care for MA and GAMC recipients are prescribed in Minnesota Statutes, section 256B.69 and Laws of Minnesota, 1997, Chapter 203, Article 4, sections 49 and 56. New amendments passed this year allow all counties, including those currently participating in PMAP, to choose whether their MA and GAMC recipients are enrolled in PMAP, or enrolled in county-based purchasing (CBP) models of prepaid managed care. Counties are given additional authority in PMAP implementation, and parameters for county based purchasing models are prescribed. The new amendments mandate that for all counties not currently participating in PMAP, initial enrollment of recipients must begin on or before January 1, 1999 under either model.

See Attachments A and B for the full text of the new legislative amendments. Following is a summary of the counties' options as contained in the legislation.

Option A: PMAP. Under this option, a county board, or a single entity representing a group of county boards, mutually selects licensed health plans (CISNs or HMOs) with DHS to serve their recipients. This selection process includes the county board's input in developing, approving and issuing the Request for Proposal (RFP). County boards are given the opportunity to review all proposals received based on the identification of community needs under the Community Social Services Act and the Community Health Services Act, and to work with DHS to improve any proposal that the county determines does not adequately meet those needs. The county board may also "recommend a maximum number participating of health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans" (MS 256B.69, sub. 3a).

The county board also has the option of developing contract requirements related to the achievement of public health goals. If the county board and DHS mutually agree to these requirements, DHS will include them in all contracts for that county. The county board may participate in the enforcement of these provisions.

The 1997 legislation has created a dispute resolution process for PMAP implementation. A panel may be convened to make recommendations to the DHS Commissioner to resolve disputes regarding the selection of health plans, contract requirements, and implementation and enforcement of the optional local public health goal contract requirements. The panel consists of one designee from each of the following: Association of Minnesota Counties; DHS; and the Minnesota Department of Health.

Option B: County-based Purchasing. Under this option, a county board or groups of counties will purchase health care services for all of their county's MA and GAMC recipients who would otherwise be enrolled in PMAP. (Note that this does NOT include persons under age 65 with disabilities, who may be included in pilot projects authorized under Laws of Minnesota, 1997, Chapter 203, Article 8, section 1, nor does it include Indians living on reservations.) Counties that choose the CBP option must purchase or provide all services included in PMAP contracts. Counties may purchase all or part of these services from health plans or individual providers on a fee-for service basis.

DHS will pay for each enrollee's care on a capitated basis for each county whose CBP final proposal is approved by DHS. Payments from DHS will be made without regard to the frequency or extent of any individual enrollee's utilization of services. DHS payments to counties will not exceed payments that would have been made to health plans under PMAP for that county or region. DHS and the federal government will not be liable for any costs incurred by a county that exceed these payments. Counties may assign risk for the cost of care to a third party.

The Minnesota Department of Health (MDH) must assure that CBP entities will meet the requirements of Chapters 62D and 62N. Counties or groups of counties that elect to implement CBP are not required to obtain a Certificate of Authority under Chapter 62D (health maintenance organizations) or Chapter 62N (community integrated service networks) from MDH. However, the county or group of counties must satisfy MDH that the requirements of Chapter 62D or Chapter 62N will be met. The county or group of counties must also assure MDH that the requirements of section 72A.201 (regulating the claims practices of insurers) will be met.

Any payments DHS makes to counties for education, enrollment and advocacy will be separate from the capitation payments. Counties operating CBP models will be held to the same requirements regarding appeals as PMAP health plans, and enrollees will have the same rights as they would under PMAP. These rights and requirements are prescribed in MS 256.045, subd. 3. DHS must obtain the full approval of the federal government required to maintain federal matching funds for the MA program before any CBP final proposal can be approved.

IV. Process/Schedule

To allow for an orderly transition for recipients whose health care plan will be affected by this legislation, DHS requests that each county notify the Department of the option the county has chosen as soon as possible, but no later than September 2, 1997. Following are the process requirements and time lines for each option.

Option A: PMAP. For counties not currently participating in PMAP who choose this option, DHS anticipates a phase-in of the development of PMAP through the issuance of multiple Requests for Proposals (RFPs). DHS will work with County Boards to establish a mutually agreeable time line for PMAP implementation, but enrollment must begin no later than January 1, 1999. DHS is prepared to begin working on implementation with the first group of counties in mid summer of this year. The development period (from the first meeting with the counties to the first date of enrollment) is approximately twelve months long. The Department will attempt to accommodate local scheduling issues in establishing the time line for the county phase-ins. Counties that choose to pursue the PMAP option may notify DHS of their intent anytime prior to September 3, 1997.

Option B: County-based Purchasing.

1) Counties wishing to implement CBP with enrollment to begin no later than January 1, 1999 must submit a preliminary proposal to DHS on or before September 2, 1997. (This includes counties currently participating in PMAP and counties which have already begun developing a CBP model.) This proposal must substantially demonstrate that the county is able to meet the requirements for CBP prescribed by Laws of Minnesota 1997, Chapter 203, Article 4, section 56. A final proposal must be submitted to DHS on or before July 1, 1998. The prescribed format and criteria for the preliminary proposals are described in Attachment C.

2) Counties wishing to implement CBP with enrollment scheduled to begin after January 1, 1999 must first implement PMAP as described above under Option A, with enrollment to begin in that program by January 1, 1999. The county must submit a preliminary CBP proposal to DHS as described above at least 15 months prior to the termination of the PMAP health plan contracts for that county, and must submit a final CBP proposal to DHS six months prior to the PMAP contracts' termination. DHS is not required to terminate PMAP contracts that begin on or after September 1, 1997 for any county submitting a CBP proposal until two years after the date of initial PMAP enrollment in that county.

Any county which discontinues CBP is prohibited from resuming CBP for a period of five years after the date it discontinues CBP.

V. County-based Purchasing Proposals

Counties wishing to submit a CBP proposal should refer to "Information for Counties: County Based Purchasing of Health Care for MA and GAMC Recipients" (Attachment C), and prepare a preliminary proposal according to the "Specifications for Preliminary Proposals" (Attachment D). A binder containing further information on CBP will be sent to each county human services director under separate cover.

If DHS rejects a county's preliminary or final proposal, the county may request review by a mediation panel. The panel would be composed of one designee from each of the following: Association of Minnesota Counties; DHS; and the Minnesota Department of Health. DHS will resolve the dispute taking into consideration the panel's recommendation.

VI. Information/Technical Assistance

DHS will provide clarification or technical assistance on the specifications included in this bulletin to any county in need of this assistance. Counties should contact the appropriate person listed on the first page of this bulletin to request this assistance.

Information on meeting the requirements of MS Chapter 62D or 62N, or MS 72A.201 is available from Kent E. Peterson, Manager, Managed Care Systems Section, Minnesota Department of Health, P.O. Box 64975, St. Paul, MN 55164-0975, telephone 612/282-5616, fax 612/282-5628, e-mail kent.peterson@health.state.mn.us.

Attachments:

A. Laws of Minnesota, 1997, Chapter 203, Article 4, section 49.
B. Laws of Minnesota, 1997, Chapter 203, Article 4, section 56.
C. Information for Counties: County-based Purchasing of Health Care for MA and GAMC Recipients
D. Specifications for Preliminary Proposals

ATTACHMENT A: Laws of Minnesota 1997, Chapter 203, Article 4, Section 49

Sec. 49. Minnesota Statutes 1996, section 256B.69, subdivision 3a, is amended to read:

Subd. 3a. [COUNTY AUTHORITY.] (a) The commissioner, when implementing the general assistance medical care, or medical assistance prepayment program within a county, must include the county board in the process of development, approval, and issuance of the request for proposals to provide services to eligible individuals within the proposed county. County boards must be given reasonable opportunity to make recommendations regarding the development, issuance, review of responses, and changes needed in the request for proposals. The commissioner must provide county boards the opportunity to review each proposal based on the identification of community needs under chapters 145A and 256E and county advocacy activities. If a county board finds that a proposal does not address certain community needs, the county board and commissioner shall continue efforts for improving the proposal and network prior to the approval of the contract. The county board shall make recommendations regarding the approval of local networks and their operations to ensure adequate availability and access to covered services. The provider or health plan must respond directly to county advocates and the state prepaid medical assistance ombudsperson regarding service delivery and must be accountable to the state regarding contracts with medical assistance and general assistance medical care funds. The county board may recommend a maximum number of participating health plans after considering the size of the enrolling population; ensuring adequate access and capacity; considering the client and county administrative complexity; and considering the need to promote the viability of locally developed health plans. The county board or a single entity representing a group of county boards and the commissioner shall mutually select health plans for participation at the time of initial implementation of the prepaid medical assistance program in that county or group of counties and at the time of contract renewal. The commissioner shall also seek input for contract requirements from the county or single entity representing a group of county boards at each contract renewal and incorporate those

recommendations into the contract negotiation process. The commissioner, in conjunction with the county board, shall actively seek to develop a mutually agreeable timetable prior to the development of the request for proposal, but counties must agree to initial enrollment beginning on or before January 1, 1999, in either the prepaid medical assistance and general assistance medical care programs or county-based purchasing under section 256B.692. At least 90 days before enrollment in the medical assistance and general assistance medical care prepaid programs begins in a county in which the prepaid programs have not been established, the commissioner shall provide a report to the chairs of senate and house committees having jurisdiction over state health care programs which verifies that the commissioner complied with the requirements for county involvement that are specified in this subdivision.

(b) The commissioner shall seek a federal waiver to allow a fee-for-service plan option to MinnesotaCare enrollees. The commissioner shall develop an increase of the premium fees required under section 256.9356 up to 20 percent of the premium fees for the enrollees who elect the fee-for-service option. Prior to implementation, the commissioner shall submit this fee schedule to the chair and ranking minority member of the senate health care committee, the senate health care and family services funding division, the house of representatives health and human services committee, and the house of representatives health and human services finance division.

(c) At the option of the county board, the board may develop contract requirements related to the achievement of local public health goals to meet the health needs of medical assistance and general assistance medical care enrollees. These requirements must be reasonably related to the performance of health plan functions and within the scope of the medical assistance and general assistance medical care benefit sets. If the county board and the commissioner mutually agree to such requirements, the department shall include such requirements in all health plan contracts governing the prepaid medical

assistance and general assistance medical care programs in that county at initial implementation of the program in that county and at the time of contract renewal. The county board may participate in the enforcement of the contract provisions related to local public health goals.

(d) For counties in which prepaid medical assistance and general assistance medical care programs have not been established, the commissioner shall not implement those programs if a county board submits acceptable and timely preliminary and final proposals under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which prepaid medical assistance and general assistance medical care programs are in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision 5, if the county board submits and the commissioner accepts preliminary and final proposals according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

(e) In the event that a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement regarding: (i) the selection of participating health plans in that county; (ii) contract requirements; or (iii) implementation and enforcement of county requirements including provisions regarding local public health goals, the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

(f) If a county which elects to implement county-based purchasing ceases to implement county-based purchasing, it is prohibited from assuming the responsibility of county-based

purchasing for a period of five years from the date it discontinues purchasing.

ATTACHMENT B: Laws of Minnesota 1997, Chapter 203, Article 4, Section 56

Sec. 56. [256B.692] [COUNTY-BASED PURCHASING.]

Subdivision 1. [IN GENERAL.] County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance and general assistance medical care who would otherwise be required to [illegible] may elect to participate in the prepaid medical assistance or prepaid general assistance medical care programs according to sections 256B.69 and 256D.03. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to sections 256B.69, subdivisions 1 to 22, and 256D.03. County-based purchasing under this section is governed by section 256B.69, unless otherwise provided for under this section.

Subd. 2. [DUTIES OF THE COMMISSIONER OF HEALTH.] Notwithstanding chapters 62D and 62N, a county that elects to purchase medical assistance and general assistance medical care in return for a fixed sum without regard to the frequency or extent of services furnished to any particular enrollee is not required to obtain a certificate of authority under chapter 62D or 62N. A county that elects to purchase medical assistance and general assistance medical care services under this section must satisfy the commissioner of health that the requirements of chapter 62D, applicable to health maintenance organizations, or chapter 62N, applicable to community integrated service networks, will be met. A county must also assure the commissioner of health that the requirements of section 72A.201 will be met. All enforcement and rulemaking powers available under chapters 62D and 62N are hereby granted to the commissioner of health with respect to counties that purchase medical assistance and general assistance medical care services under this section.

Subd. 3. [REQUIREMENTS OF THE COUNTY BOARD.] A county board that intends to purchase or provide health care under this

section, which may include purchasing all or part of these services from health plans or individual providers on a fee-for-service basis, or providing these services directly, must demonstrate the ability to follow and agree to the following requirements:

(1) purchase all covered services for a fixed payment from the state that does not exceed the estimated state and federal cost that would have occurred under the prepaid medical assistance and general assistance medical care programs;

(2) ensure that covered services are accessible to all enrollees and that enrollees have a reasonable choice of providers, health plans, or networks when possible. If the county is also a provider of service, the county board shall develop a process to ensure that providers employed by the county are not the sole referral source and are not the sole provider of health care services if other providers, which meet the same quality and cost requirements are available;

(3) issue payments to participating vendors or networks in a timely manner;

(4) establish a process to ensure and improve the quality of care provided;

(5) provide appropriate quality and other required data in a format required by the state;

(6) provide a system for advocacy, enrollee protection, and complaints and appeals that is independent of care providers or other risk bearers and complies with section 256B.69;

(7) for counties within the seven-county metropolitan area, ensure that the implementation and operation of the Minnesota senior health options demonstration project, authorized under section 256B.69, subdivision 23, will not be impeded;

(8) ensure that all recipients that are enrolled in the prepaid medical assistance or general assistance medical care program will be transferred to county-based purchasing without utilizing the department's fee-for-service claims payment system;

(9) ensure that all recipients who are required to

participate in county-based purchasing are given sufficient information prior to enrollment in order to make informed decisions; and

(10) ensure that the state and the medical assistance and general assistance medical care recipients will be held harmless for the payment of obligations incurred by the county if the county, or a health plan providing services on behalf of the county, or a provider participating in county-based purchasing becomes insolvent, and the state has made the payments due to the county under this section.

Subd. 4. [PAYMENTS TO COUNTIES.] The commissioner shall pay counties that are purchasing or providing health care under this section a per capita payment for all enrolled recipients. Payments shall not exceed payments that otherwise would have been paid to health plans under medical assistance and general assistance medical care for that county or region. This payment is in addition to any administrative allocation to counties for education, enrollment, and advocacy. The state of Minnesota and the United States Department of Health and Human Services are not liable for any costs incurred by a county that exceed the payments to the county made under this subdivision. A county whose costs exceed the payments made by the state, or any affected enrollees or creditors of that county, shall have no rights under chapter 61B or section 62D.181. A county may assign risk for the cost of care to a third party.

Subd. 5. [COUNTY PROPOSALS.] (a) On or before September 1, 1997, a county board that wishes to purchase or provide health care under this section must submit a preliminary proposal that substantially demonstrates the county's ability to meet all the requirements of this section in response to criteria for proposals issued by the department on or before July 1, 1997. Counties submitting preliminary proposals must establish a local planning process that involves input from medical assistance and general assistance medical care recipients, recipient advocates, providers and representatives of local school districts, labor, and tribal government to advise on the development of a final

proposal and its implementation.

(b) The county board must submit a final proposal on or before July 1, 1998, that demonstrates the ability to meet all the requirements of this section, including beginning enrollment on January 1, 1999.

(c) After January 1, 1999, for a county in which the prepaid medical assistance program is in existence, the county board must submit a preliminary proposal at least 15 months prior to termination of health plan contracts in that county and a final proposal six months prior to the health plan contract termination date in order to begin enrollment after the termination. Nothing in this section shall impede or delay implementation or continuation of the prepaid medical assistance and general assistance medical care programs in counties for which the board does not submit a proposal, or submits a proposal that is not in compliance with this section.

(d) The commissioner is not required to terminate contracts for the prepaid medical assistance and prepaid general assistance medical care programs that begin on or after September 1, 1997, in a county for which a county board has submitted a proposal under this paragraph, until two years have elapsed from the date of initial enrollment in the prepaid medical assistance and prepaid general assistance medical care programs.

Subd. 6. [COMMISSIONER'S AUTHORITY.] The commissioner may:

(1) reject any preliminary or final proposal that substantially fails to meet the requirements of this section, or that the commissioner determines would substantially impair the state's ability to purchase health care services in other areas of the state, or would substantially impair an enrollee's choice of care systems when reasonable choice is possible, or would substantially impair the implementation and operation of the Minnesota senior health options demonstration project authorized under section 256B.69, subdivision 23; and

(2) assume operation of a county's purchasing of health care for enrollees in medical assistance and general assistance

terminated.

Subd. 7. [DISPUTE RESOLUTION.] In the event the commissioner rejects a proposal under subdivision 6, the county board may request the recommendation of a three-person mediation panel. The commissioner shall resolve all disputes after taking into account the recommendations of the mediation panel. The panel shall be composed of one designee of the president of the association of Minnesota counties, one designee of the commissioner of human services, and one designee of the commissioner of health.

Subd. 8. [APPEALS.] A county that conducts county-based purchasing shall be considered to be a prepaid health plan for purposes of section 256.045.

Subd. 9. [FEDERAL APPROVAL.] The commissioner shall request any federal waivers and federal approval required to implement this section. County-based purchasing shall not be implemented without obtaining all federal approval required to maintain federal matching funds in the medical assistance program.

Subd. 10. [REPORT TO THE LEGISLATURE.] The commissioner shall submit a report to the legislature by February 1, 1998, on the preliminary proposals submitted on or before September 1, 1997.

Attachment C

Information for Counties: County-based Purchasing (CBP) of Health Care for MA and GAMC Recipients (Laws of Minnesota 1997, Chapter 203, Article 4, Section 56):

All County-based Purchasing (CBP) of health care for Medical Assistance (MA) and General Assistance Medical Care (GAMC) Recipients will be subject to the requirements of Minnesota Statutes, section 256B.69, subdivisions 1 through 22. DHS will evaluate preliminary and final proposals on their substantial demonstration of the county's ability to meet the following requirements:

Covered Population
Requirement: Each county or multi-county entity which elects to purchase health care services on behalf of MA and GAMC recipients must cover all MA and GAMC recipients who would otherwise be required or elect to participate in the Prepaid Medical Assistance Program (PMAP).

Requirement: Each County Based Purchasing (CBP) entity must purchase for a sufficient number of enrollees to ensure financial stability of the CBP. Proposals must demonstrate ability to secure reinsurance or other strategies to guard against insolvency. Proposals with fewer than 3,000 potential enrollees will be required to provide additional documentation on how these insolvency protections will be implemented.

- Note: Projected enrollment can be estimated at 80% of the total MA and GAMC population residing in any county. Tribal members living on reservations are also excluded from enrollment.

Covered Services, Payments to Counties
Requirement: Each county or multi-county entity must purchase all required MA and GAMC services for a fixed payment.

Access
Requirement: Each county or multi-county entity must ensure access of all covered services to all of its enrollees.

Choice
Requirement: Each county or multi-county entity must ensure a reasonable choice of providers, health plans or networks for its enrollees.

Requirement: County based purchasing (CBP) must not substantially impair an enrollee's choice of care systems when reasonable choice is possible. DHS will evaluate proposals compared to the level of choice that is currently offered (7/1/97) for the Prepaid Medical Assistance/General Assistance Medical Care Program (PMAP), or for counties in which PMAP is not yet operational,

for MinnesotaCare. A reduction in the level of choice must be justified based on improved patient care or on choice offered through different contracting arrangements.

Providers will be considered to be in the same care system if they are linked in any of the following ways:

- the providers are employed by one organization
- the providers receive a portion of their reimbursement based on the performance of the group as a whole (single risk pool for similar providers)
- one system, set of criteria, or process for prior authorization of health care services
- one system, set of criteria, or process for specialty provider referral authorization
- one option for major specialty or ancillary care provider referrals

Requirement: Metro area CBPs must assure continued choice for MSHO enrollees.

Payments to Providers
Requirement: Each county or multi-county entity must issue payments to its participating providers in a timely manner, pursuant to the requirements of 72A.

Quality Improvement
Requirement: Each county or multi-county entity must establish a process to ensure/improve the quality of care.

Data Requirements
Requirement: Each county or multi-county entity must provide appropriate quality and other data as required by state.

Advocacy, Complaints
Requirement: Each county or multi-county entity must provide a system for advocacy, protection and complaints that is independent of its care providers or risk bearers.

Impact on Other DHS Purchasing Activities
Requirement: Each county or multi-county entity must ensure that its purchasing activities will not substantially impair the implementation and operation of MSHO.

Requirement: Each county or multi-county entity must ensure that its purchasing activities will not substantially impair the state's ability to purchase health care services in other areas of the state.

Requirement: Proposals that would isolate a county or a group of counties will not be

approved, if it is determined that it is not feasible for DHS to secure PMAP contracts for the isolated county or counties.

Requirement: Each county or multi-county entity which has MA or GAMC recipients enrolled in PMAP must ensure that its PMAP enrollees are transferred to CBP without using the DHS fee-for-service claims payment system.

Enrollment Information
Requirement: Each county or multi-county entity must ensure that its recipients are given sufficient information prior to enrollment to make informed decisions.

Solvency
Requirement: Each county or multi-county entity must ensure that the State and the county's MA recipients are held harmless in event of insolvency of a provider or of a county purchasing entity.

Regulatory Review and Plan Design
Requirement: Each county or multi-county entity must satisfy the Minnesota Department of Health that its purchasing activities will meet the requirements of Minnesota Statutes, Chapter 62D or 62N.

Requirement: Each county or multi-county entity must satisfy the Minnesota Department of Health that its purchasing activities will meet the requirements of Minnesota Statutes, section 72A.201.

Requirement: Each county or multi-county entity must meet similar administrative and regulatory requirements as specified in the contract between DHS and the health plans participating in PMAP. DHS will work with counties to determine how these requirements can best be met under CBP.

Local Planning Process
Requirement: Each county or multi-county entity must establish a local planning process that involves input from MA and GAMC recipients, recipient advocates, providers, representatives of local school districts, labor and tribal governments to advise on the development of a final proposal and its implementation.

Attachment D

Specifications for Preliminary Proposals

Please respond completely to each item below. Identify each item as specified in the Response Format given on page 4.
Each preliminary proposal must include the following:

1) Governance, geographical coverage

A. Identification of county(ies) submitting this proposal.

B. Number of potential MA and GAMC enrollees served by the CBP listed by county and the total number of potential MA and GAMC enrollees.

C. Copies of board resolutions authorizing county participation in county-based purchasing. Resolutions must list all counties participating in the proposal. Resolutions must specify intent to develop and implement a CBP and enroll eligible recipients not later than 1/1/99.

D. A description of the proposed governance (e.g., joint powers agreement) and its current status.

E. A description of how the purchasing activities will be separated administratively and financially from all other county operations.

F. The name, title and telephone number of a designated contact person.

2) Network development

A. A preliminary analysis of the local health care market including:
   - i. identification of primary care providers, individual providers, provider groups, care systems and health plans doing business in the county(ies) submitting the proposal and surrounding counties;
   - ii. identification of existing utilization and referral patterns; and
   - iii. access/availability issues for all covered services.

B. A work plan giving major activities, key events, and time lines, for developing the network. The work plan must address:
   - i. How the CBP will develop a network that will meet the access requirements of MN Rules, part 4685.1010.
   - ii. How the county will provide needed services, especially specialty or tertiary care services, outside the CBP's service area.
   - iii. How the CBP will ensure enrollee choice of providers and care systems.
   - iv. How the CBP will develop financial and risk-sharing arrangements with providers.
   - v. For Metro counties and any other counties where MSHO is operational only: How the CBP will assure continued choice of MSHO qualified contractors for MSHO enrollees.

3) Care management/utilization review/prior authorization

A. A work plan giving major activities, key events and time lines for developing a process or contract(s) for implementing a utilization review system, defining medical necessity, and establishing a prior authorization system. The work plan must also identify general strategies the CBP will use to manage care.

4) Administrative, data and payment systems

A. A work plan giving major activities, key events, and time lines for developing the necessary administrative, claims payment and information systems. The work plan must address administrative and information systems for :

i. enrollment processing,
ii. encounter data,
iii. claims processing and payment, and
iv. remittance data transfers

5) Quality improvement system

A. A work plan giving major activities, key events, and time lines for developing the quality improvement system that will meet the requirements of Minnesota Statutes Chapter 62D or 62N, and the requirements of the Model County Based Purchasing Agreement.

6) Data

A. A statement that the CBP will provide data to DHS in accordance with the requirements of the Model County Based Purchasing Agreement.

7) Advocacy/complaint system

A. A work plan giving major activities, key events and time lines for developing a complaint system that will meet the requirements of the Model County Based Purchasing Agreement.

B. A description of the CBP's strategies to ensure that the advocacy/complaint system will be independent of the CBP's care providers and risk bearers.

8) Legal requirements

A. A work plan giving major activities, key events and time lines for developing the submission to MDH regarding meeting the requirements of Section 62D or Section 62N by March 1, 1998.

9) Solvency

A. A work plan giving major activities, key events and time lines to develop strategies the CBP will employ to protect itself against insolvency, and identification of reserve funds available to the CBP for this purpose, or a description of the process the CBP will use to build such reserves.

B. A statement assuring that the CBP will hold harmless both its recipients and the State in the event of insolvency.

10) Local planning process

A. Identify groups and individuals who will be invited to participate in the local planning process to advise on the development of a final proposal and its implementation.

B. An implementation plan for the local planning process for CBP including major activities, key events, and time lines.

Attachment D

Format for Preliminary Proposals

To facilitate review of preliminary proposals, please number each page of the proposal. Please identify each response item with the appropriate alpha/numeric characters and section heading for each item:

For example:
Item 2) Network Development A) (i)

Submission of Preliminary Proposals

Each respondent must submit three copies of the preliminary proposal to:

James Chase, Director
Purchasing and Service Delivery Division
Minnesota Department of Human Services
444 Lafayette Road
St. Paul, MN 55155-3854

Proposals are due at the Department of Human Services by September 2, 1997 at 5:00 p.m.

Criteria for Approval of Preliminary Proposals

All responses received by the deadline of September 2, 1997 will be evaluated on the following criteria:

1) Each of the ten Specifications for Preliminary Proposals must be completely and fully addressed; and
2) Adequate details must be provided in the information (includes all required identifications, statements, descriptions, and work plan) which demonstrate the county's (ies') full understanding and ability to perform as a CBP entity.

Specifications for Final Proposals

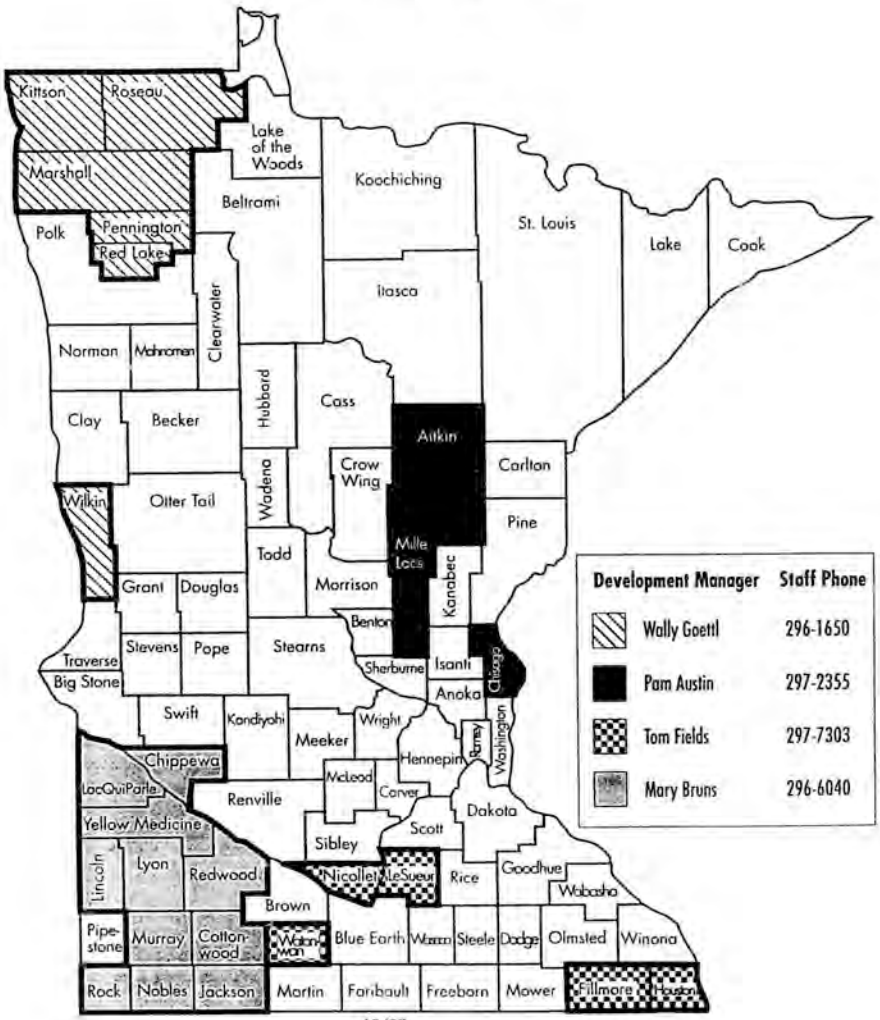
DHS will publish the specifications for final proposals not later than April 15, 1998.

Attachment D

Time Line

July 1, 1997	Preliminary proposal criteria published by DHS
July - September 1997	DHS/MDH communication with County Boards
September 2, 1997	Preliminary proposals due to DHS
September 1997 -- June 30, 1998	County local planning process
September 15 -- November 15, 1997	Initial DHS response to counties
October 15 -- December 15, 1997	County response to clarifications requested by DHS in initial response
December 15, 1997	DHS produces initial draft of criteria for evaluation of final CBP proposals
January 15, 1998	County update to DHS on status of work plans
February 1, 1998	DHS submits Progress Report to Legislature
March 1, 1998	County submits preliminary information to MDH
April 15, 1998	Final proposal criteria published by DHS
July 1, 1998	Final proposals due to DHS
August 17, 1998	DHS notifies respondents of intent to negotiate Agreement
October 1, 1998	Agreements finalized
October- December 1998	Enrollment process begins
January 1, 1999	Enrollee access begins

PMAP Expansion



10/97
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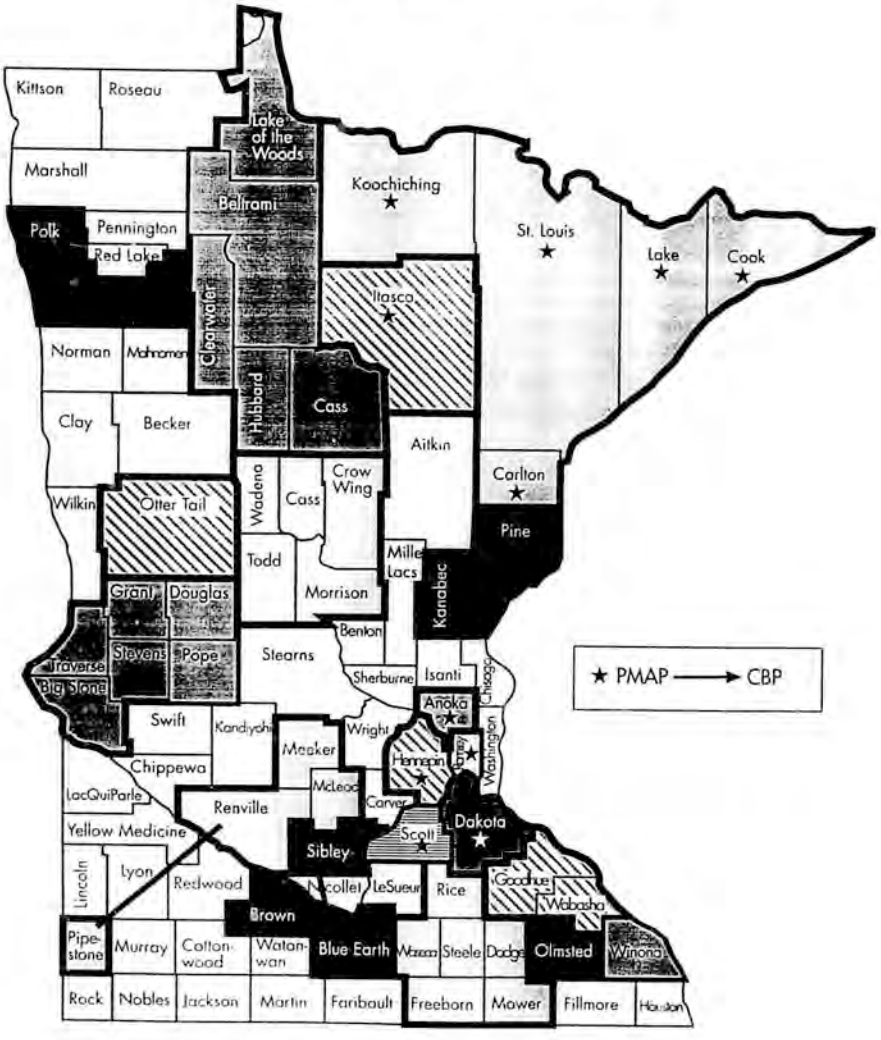
CBP Proposals Received



Minnesota Department of **Human Services**

County Based Purchasing Proposals

As of 5:00 p.m. September 2, 1997, the Minnesota Department of Human Services has received 19 preliminary proposals involving 47 counties who proposed plans to develop county based purchasing initiatives.

The proposals are dispersed throughout the state. Eleven counties currently in PMAP (five metro, six non-metro) have submitted preliminary proposals. One county is involved in two proposals. The 40 counties that did not submit proposals will continue PMAP implementation so that all will have begun PMAP enrollment by January 1999.

The department will review each preliminary proposal and provide comments back to counties by November 15, 1997. Counties will respond to these comments by December 15, 1997, and will provide an update on the status of progress on their work plans to the department by January 15, 1998. On February 1, 1998, the department will report progress to the Legislature. Final proposals are due to the department by July 1, 1998, with enrollment in approved county plans to begin no later than January 1, 1999. Preliminary county based purchasing proposals: September 2, 1997:

Northwest (1 proposal)
1 county: Polk

North Central (3 proposals)
5 counties: Beltrami, Cass (partial), Clearwater, Hubbard, Lake of the Woods
5 counties: Cass (partial), Crow Wing, Morrison, Todd, Wadena
1 county: Itasca

Northeast (1 proposal)
5 counties: Carlton, Cook, Koochiching, Lake, St. Louis

West Central (2 proposals)
6 counties: Big Stone, Douglas, Grant, Pope, Stevens, Traverse
1 county: Otter Tail

Central with ties Southwest (1 proposal)
4 counties: Renville, Meeker, McLeod, Pipestone

Metro (5 proposals)
1 county: Anoka
1 county: Dakota
1 county: Hennepin
1 county: Ramsey
1 county: Scott

Southeast (4 proposals)
6 counties: Dodge, Freeborn, Mower, Rice, Steele, Waseca
2 counties: Goodhue, Wabasha
1 county: Olmsted
1 county: Winona

East Central (1 proposal)
2 counties: Kanabec, Pine

South Central (1 proposal)
3 counties: Blue Earth, Brown, Sibley

COUNTY BASED PURCHASING
COORDINATED DATA REQUEST

CLAIMS DETAIL EXTRACT		
	Field	***Description***
1	Encrypted Client ID	Encrypted client ID, each client should have a single ID.
2	County of Residence	County of residence of the client at the time the procedure/**claim** was processed.
3	Eligibility Type	Category under which the client was eligible for coverage at the time the procedure/**claim** was provided.
4	Client Age	Bands associated with PPHP at time of procedure. **0 - 1; 2 -15; 16 - 49; 50 - 64; 65 - 74; 75 - 84; 85+**
5	Client Gender	
6	**First** Date of Service Admit Date	Date at the time the procedure/**claim** was provided (admission date for inpatient hospital services).
7	Date of Payment	Date at which the provider was reimbursed for the procedure/**claim**.
8	Covered Procedure Flag	Flag indicating whether or not the procedure/**claim** is covered under PPHP contracting (Y or N).
9	Provider Number (encrypted)	"Pay-To" provider number. Name is not useful when two providers have the same name.
10	Provider Site of Service	Zip code of the "Pay-To" name.
11	Provider Specialty **Provider Type**	Provider **Type** or (if applicable) **primary** speciality category.
12	Location **(use Type of Bill, Type of Admission and Place of Service)**	Location associated with the procedure provided (inpatient hospital, emergency room, etc.)
13	**Minnesota** Category of Service	DHS defined category of service.
14	UB 92 Revenue Code	When available.
15	ICD Diagnosis Code (Primary)	Primary ICD 9 Diagnosis Code as submitted by the provider.
16	ICD Diagnosis Code (Secondary)	Secondary ICD 9 Diagnosis Code as submitted by the provider, where available.
17	ICD Diagnosis Code (Third) ICD Diagnosis Code (Fourth)	Third a[illegible]ourth [illegible]vel of ICD Diagnosis Codes as submitted by the provider, where available.
18	Procedure Code	DRG, CPT/HCPCS, CDT, or other procedure codes as identified by the providers submitting claims.
19	Procedure Code Modifier 1 **Procedure Code Modifier 2**	Modifiers to procedure codes submitted by providers, if available.

COUNTY BASED PURCHASING
COORDINATED DATA REQUEST

	Field	*Description*
20	Units of Service **Paid or number of 'Covered Days' from UB-92**	Number of units provided during the procedure (days for IP hospital services, etc.)
21	Billed Amount	Amount billed by the provider.
22	Paid Amount	Amount paid to provider under FFS excluding third party reimbursements.
23	Other Payor 1 **(UB-92 only)**	Reimbursements from other payors.
24	Payor 1 Type	Type of payor responsible for payments identified in Payor 1.
25	Other Payor 2	Reimbursements from other payors after Payor 1.
26	Payor 2 Type	Type of payor responsible for payments identified in Payor 2.
27	Other Payor 3	Reimbursements from any other payors beyond Payor 2.
28	Payor 3 Type	Type of payor responsible for payments identified in Payor 3. First payor if multiple Payor 3s.
29	Living Arrangement	Living arrangement at the time claim was processed.
30	Provider Type (see #11)	

ELIGIBILITY DETAIL EXTRACT		
	Field	*Description*
31	Encrypted Client ID	Encrypted client ID, each client should have a single ID.
32	Calendar Year	Calendar year of eligibility.
33	County of Residence	County of residence of the client at the time the procedure claim was processed.
34	Eligibility Criteria	PPHP categories.
35	Client Age	Bands associated with PPHP as end of reporting period.
36	Client Gender	
37	Eligibility Months	Months of eligibility in calendar year associated with the combination of demographic characteristics.

COUNTY BASED PURCHASING
COORDINATED DATA REQUEST

TOTAL REPORT - BILLED AND PAID BY COUNTY		
	Field	*Description*
38	Calendar Year	Calendar year in which the procedure was provided.
39	County	Client's county of residence at the time claim was processed.
40	Covered Procedure Flag	Indicating whether or not PPHP covered service.
41	Units of Service Paid	Numeric field summarized by sort criteria.
42	Number of Procedures	Numeric field summarized by sort criteria.
43	Billed Amount	Numeric field summarized by sort criteria.
44	Paid Amount	Numeric field summarized by sort criteria.

TOTAL REPORT - BILLED AND PAID BY SPECIALTY		
	Field	*Description*
45	Calendar Year	Calendar year in which the procedure was provided.
46	County	Client's county of residence.
47	Covered Procedure Flag	Indicating whether or not PPHP covered service.
48	Provider Specialty	Provider type of (if applicable) specialty category (1st only).
49	Units of Service	Numeric field summarized by sort criteria.
50	Number of Procedures	Numeric field summarized by sort criteria.
51	Billed Amount	Numeric field summarized by sort criteria.
52	Paid Amount	Numeric field summarized by sort criteria.

TOTAL REPORT - EXPOSED MONTHS		
	Field	*Description*
53	Calendar Year	Calendar year of eligibility.
54	County	Client's county of residence.
55	Eligibility Types	Category under which the client was eligible for coverage.
56	Eligibility Months	Numeric field summarized by sort criteria.

COUNTY BASED PURCHASING
COORDINATED DATA REQUEST

TOTAL REPORT - COST PATTERNS		
	Field	*Description*
57	Calendar Year	Calendar year in which the procedure was provided.
58	County	Client's county of residence.
59	Covered Procedure Flag	Indicating whether or not PPHP covered service.
60	Expenditure Tier	$0; $1-$9,999; $10,000-$24,999; $25,000-$49,999; $50,000-$74,999; $75,000-$99,999; $100,000+.
61	Number Unduplicated Clients	The number of unduplicated clients with total annual expenses within the expenditure tier.
62	Total Paid Claims	The total paid expenses associated with the unduplicated clients.

TOTAL REPORT - PHYSICIAN COST PATTERNS		
	Field	*Description*
63	Calendar Year	Calendar year in which the procedure was provided.
64	County	Client's county of residence.
65	Covered Procedure Flag	Indicating whether or not PPHP covered service.
66	Physician Expenditure Tier	$0; $1-$9,999; $10,000-$24,999; $25,000-$49,999; $50,000-$74,999; $75,000-$99,999; $100,000+.
67	Number Unduplicated Clients	The number of unduplicated clients with total annual expenses within the physician expenditure tier.
68	Total Paid Claims	The total paid expenses associated with the unduplicated clients.

TOTAL REPORT - HOSPITAL COST PATTERNS INPATIENT ONLY		
	Field	*Description*
69	Calendar Year	Calendar year in which the procedure was provided.
70	County	Client's county of residence.
71	Covered Procedure Flag	Indicating whether or not PPHP covered service.
72	Hospital Expenditure Tier	$0; $1-$9,999; $10,000-$24,999; $25,000-$49,999; $50,000-$74,999; $75,000-$99,999; $100,000+.
73	Number Unduplicated Clients	The number of unduplicated clients with total annual expenses within the hospital expenditure tier.
74	Total Paid Claims	The total paid expenses associated with the unduplicated clients.

COUNTY BASED PURCHASING
COORDINATED DATA REQUEST

TOTAL REPORT - PHARMACY PATTERNS		
	Field	***Description***
75	Calendar Year	Calendar year in which the procedure was provided.
76	County	Client's county of residence.
77	Eligibility Criteria	As previously identified.
78	Total Volume	Number of prescriptions for pharmacy costs only, multiple prescriptions will be identified.
79	Total Wholesale Costs	Total wholesale costs for pharmacy.
80	Total Paid Claims	Total paid amounts for pharmacy.

PARTICIPATING PROVIDERS REPORT (Not from Data Warehouse)		
	Field	***Description***
81	Participating Providers	For all providers registered with DHS as eligible for fee-for-service reimbursement that have been billed within the past 12 months, and are located in Minnesota (5-state area) adjoining states/provinces: (a) name; (b) unique (encoded) identifying number; (c) provider type; (d) specialty; and (e) practice address.