

2-1800-8504-1

STATE OF MINNESOTA  
OFFICE OF ADMINISTRATIVE HEARINGS  
FOR THE DEPARTMENT OF HUMAN SERVICES

Proposed Permanent Rules Governing  
Department Health Care Program  
Participation Requirements for Vendors  
and Health Maintenance Organizations  
REPORT OF THE  
ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Bruce D. Campbell, Administrative Law Judge from the State Office of Administrative Hearings, on March 3, 1994, at 9:30 a.m. at the Regional Offices of the Minnesota State Lottery in Eagan, Minnesota, and continued until all interested persons present had an opportunity to participate by asking questions and presenting oral and written comments.

This Report is part of a rule hearing procedure required by Minn. Stat. §§ 14.01 - 14.28 (1993) to determine whether the proposed rules governing Department health care program participation requirements for vendors and health maintenance organizations should be adopted by the Commissioner of the Department of Human Services. Patricia A. Sonnenberg, Assistant Attorney General, Suite 200, 520 Lafayette Road, St. Paul, Minnesota 55155, appeared on behalf of the Minnesota Department of Human Services (Department), as legal counsel. Members of the panel appearing at the hearing for the Agency included: Martha O'Toole, Rules Coordinator; Kathleen Schuler; and Kathleen Cota. Other individuals from the Department of Human Services were available in the audience to respond to public questions. No witness was solicited by the Agency to appear on its behalf.

Eighteen members of the public signed the hearing register at the hearing and a number of members of the public provided oral and written comments at the hearing. During the hearing, the Agency submitted Exhibits 1 through 12, inclusive. The period for submitting initial comments closed on March 23, 1994. Prior to the date for the close of the receipt of initial comments, the Agency submitted a written response to the oral comments made at the public hearing and written comments received earlier in the written comment period. The record of this proceeding closed for all purposes on March 30, 1994, the date set by the Administrative Law Judge at the hearing for the receipt of reply comments as authorized by the Minnesota Administrative Procedure Act.

Pursuant to the Minnesota Administrative Procedure Act, the time for the filing of this Report was extended by the Chief Administrative Law Judge to May 5, 1994. This Report was issued within the period of extension authorized by the Chief Administrative Law Judge.

This Report must be available for review to all affected individuals upon request for at least five working days before the agency takes any further action on the rule(s). The agency may then adopt a final rule or modify or withdraw its proposed rule. If the Commissioner makes changes in the rule other than those recommended in this report, she must submit the rule with the complete hearing record to the Chief Administrative Law Judge for a review of the changes prior to final adoption. Upon adoption of a final rule, the agency must submit it to the Revisor of Statutes for a review of the form of the rule.

The agency must also give notice to all persons who requested to be informed when the rule is adopted and filed with the Secretary of State.

Based upon all the testimony, exhibits, and written comments, the Administrative Law Judge makes the following:

#### FINDINGS OF FACT

## Procedural\_Requirements

1. On January 12, 1994, the Agency filed the following documents with the Chief Administrative Law Judge:

- (a) A copy of the proposed rules certified by the Revisor of Statutes.
- (b) The Order for Hearing.
- (c) The Notice of Hearing proposed to be issued.
- (d) A Statement of the number of persons expected
- (e) The Statement of Need and Reasonableness.
- (f) A Statement of Additional Notice.
- (g) A Fiscal Note.

2. On January 31, 1994, a Notice of Hearing and a copy of the proposed rules were published at 18 State Register 1791.

3. On January 26, 1994, the Agency mailed the Notice of Hearing to all persons and associations who had registered their names with the Agency for the purpose of receiving such notice.

4. On February 4, 1994, the Agency filed the following documents with the Administrative Law Judge:

- (a) The Notice of Hearing as mailed.
- (b) The Agency's certification that its mailing list was accurate and complete.
- (c) The Affidavit of Mailing the Notice to all persons on the Agency's list.
- (d) An Affidavit of Additional Notice.
- (e) The names of Agency personnel who will represent the Agency at the hearing together with the names of any other witnesses solicited by the Agency to appear on its behalf.
- (f) A copy of the State Register containing the proposed rules.
- (g) All materials received following a Notice of Intent to Solicit Outside Opinion published at 16 State Register 2992, June 29, 1992, and a copy of that Notice.

The documents were available for inspection at the Office of Administrative Hearings from the date of filing to the date of the hearing.

5. The period for submission of written comment and statements remained open through March 23, 1994, the period having been extended by order of the Administrative Law Judge to 20 calendar days following the hearing. The record closed on March 30, 1994, the fifth business day following the close of the initial comment period.

6. After the hearing, in the Agency's initial comments and reply comments, a number of amendments to the proposed rules were submitted to the Administrative Law Judge. The revisions were filed in response to public comments made at the hearing and in written comments to the Administrative Law Judge. Each of the amendments proposed by the Department will be considered under the specific proposed rule concerned.

#### Nature\_of\_Proposed\_Rules

7. Minn. Stat. § 256B.0644 (1993), requires vendors of medical care and health maintenance organizations to participate as a provider or contractor in the Medical Assistance, General Assistance Medical Care and MinnesotaCare programs (Department Health Care Programs) in order to participate in other specified state health insurance plans. Providers other than health maintenance organizations 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% of the provider's patients. The Commissioner of Human Services must establish participation requirement for health maintenance organizations and provide quarterly lists of participating providers to the Commissioners of Commerce, Employee Relations and Labor and Industry. These Commissioners in turn must develop procedures to exclude nonparticipating providers from the programs under their jurisdiction (state Health care insurance plans). The proposed rules establish requirements for participation by providers and health maintenance organizations in the Department Health Care Programs, specified above.

#### Statutory\_Authority

8. The Agency's statutory authority to adopt the proposed rules is contained in Minn. Stat. § 256B.0644 (1993). Under this statute, the Agency has the necessary statutory authority to adopt the proposed rules.

#### Small\_Business\_Considerations

9. Minn. Stat. § 14.115, subd. 2 (1993), requires that an agency, when proposing rules that may affect small businesses, consider stated methods for reducing the impact on such small businesses of compliance requirements. Minn. Stat. § 14.115, subd. 7(3) (1993), however, excludes providers of medical care from the the advisory committee that helped formulate the proposed rules and by involving in the advisory committee members of provider associations that would represent many small business service providers. The Department also provided additional notice of the hearing to a variety of interested persons, some of which were small business medical service providers. Dept. Ex. 10.

#### Cost\_to\_Local\_Public\_Bodies

10. Minn. Stat. § 14.11, subd. 1 (1993), requires the Agency to include a statement of the rules estimated cost to local public bodies in the Notice of Intent to Adopt Rules, if the rules would have a total cost of over \$100,000 to all local public governmental bodies in the State in either of the two years immediately following adoption of proposed rules. The adoption of the proposed rules would not result in such an expenditure by local governmental bodies. The fiscal note prepared by the Department, Dept. Ex. 4, shows a zero fiscal impact of the proposed rules on local and state governmental bodies during fiscal years '93 and '94. The fiscal note was prepared as required by Minn. Stat. § 3.98, subd. 2 (1993). The Notice of and Order for Hearing contained a statement that the Fiscal Note was available from the Department upon request.

#### Uncontested\_Provisions

11. Some of the proposed rule provisions received no negative public comment either at the hearing or in subsequent filed written comments. Proposed rules which received no negative public comment were adequately supported by the Statement of Need and Reasonableness (SONAR). This Report will not specifically address those provisions in the discussion below, unless the Agency has proposed an amendment to such an uncontested provision, for purposes of clarity. It is found that the need for and reasonableness of the proposed rules which are not specifically hereinafter discussed has been demonstrated and that the Agency has statutory authority to adopt such rules.

12. The balance of this Report will address the degree to which the Department has documented its statutory authority and demonstrated the need for and reasonableness of those provisions of the rules which received negative public comment or suggestions for modification.

#### Specific\_Provisions\_of\_Proposed\_Rules

#### Part\_9505.5220: \_\_Conditions\_of\_Participation;\_Vendor\_Other\_Than\_Health\_Maintenance\_Organization.

13. Part 9505.5220 sets the conditions of participation in State Health Care Programs, as listed in Part 9505.5210, subd. 14, as regards a vendor other than a Health Maintenance Organization. Subpart 1 of Part 9505.5220 received no adverse public comments at the hearing or in subsequent written submissions.

As previously discussed, it is, therefore, found to be both needed and reasonable.

14. Subpart 2 of Part 9505.5220 was amended at line 29 on page 3 of the draft of the rules proposed by the Revisor of Statutes as a consequence of the public comment. The phrase "and B" was dropped and the phrase "to C" was added. This change is needed and reasonable to make the preamble or introduction to subpart 2 appropriately accommodate the addition of an item C to subpart 2, hereinafter discussed. The change in the introduction to subpart 2 at page 3, line 29 of the Revisor's draft of the proposed rules is not a

substantial change within the meaning of Minn. Stat. §14.15, subd. 3 (1993) and Minn. Rules, pt. 1400.1000, subp. 1 (1991), and pt. 1400.1100 (1991).

15. Subpart 2A of Part 9505.5220 states that under certain conditions, a vendor who fails to comply is not excluded from participating in insurance plans offered to local government employees. The Legal Services Advocacy Project, in its comments of March 23, 1994, stated that the meaning of the term "insurance plans offered to local government employees" should be clarified. The Legal Services Advocacy Project includes a specific suggestion for clarification at page 1 of its comments of March 23, 1994. In its 20-Day Response t

16. A number of commentators suggested that under certain circumstances a vendor should be exempt from compliance when, due to the rules of the federal government, such compliance would be impossible. A discussion of that problem was presented, on the record, by Winston W. Borden, acting as attorney for the Physical Therapy Association and Robin Saunders of Saunders Therapy Center. A virtually identical written comment was provided by the following: Barbara Cochran, Rehab Services, Inc.; Minnesota Occupational Therapy Association; Winston W. Borden, Hessian, McKasy & Soderberg; Rattray Rehab; Spectrum Therapy Centers; Multicenter Therapy; Two Rivers Center; Gallery Physical Therapy Center, Inc.; Teamwork Industrial Rehabilitation, Inc.; Two Rivers Center; Wenger Physical Therapy; and Orthopaedic Sports, Inc.

The problem described in the record results from the federal certifications for independently-owned physical therapy agencies. Federal Medical Assistance certification rules require Medicare certification. Medicare does not certify independently-owned physical therapy agencies, but does certify individual physical therapists. The Federal Health Care Financing Administration has refused in the past to allow exceptions to the requirement that Medical Assistance providers be Medicare-certified. The result of the federal rules would exclude independently-owned physical therapy agencies from other state health care programs because the physical therapy agency could not

be Medicare-certified and enroll as a Medical Assistance provider. Some modification was required to provide a mechanism for an independently-owned physical therapy agency to provide services to recipients and continue to provide access to services to clients from other state health care programs.

17. In response to the public comment, the Agency proposed the following additional item under Part 9505.5220, subp. 2 after line 6 of the Revisor's draft:

C. An independently-owned physical therapy agency or occupational therapy agency, other than a Medicare-certified rehabilitation agency is not subject to the requirements of this part if:

- (1) the agency is owned by at least one physical therapist or occupational therapist who is individually Medicare-certified and enrolled as a provider in the department health care programs;
- (2) the agency accepts recipients on a continuous basis; and
- (3) all health services provided recipients are provided by a therapist who is individually Medicare-certified.

This item does not require an agency to provide services to recipients that the agency does not provide other clients.

Department Five-Day Responsive Comments, p. 1.

The Administrative Law Judge finds that this modification, made in response to public comment, is needed and reasonable as providing a mechanism for an independently-owned physical therapy or occupational therapy agency to provide services to recipients and continue to provide access to services to clients from other state health care programs. It is necessary that physical therapy and occupational therapy services provided recipients be kept Medicare-certified because it assures Medicare payment for recipients eligible for Medicare and thereby maximizes federal financial participation in the Minnesota Medical Assistance program, as required under Minn. Stat. § 256B.04, subd. 4 (1993). As discussed by the Department in its 20-Day Response to Public Comments, the maximization of Medicare payments is an appropriate state

objective. Eighty to ninety percent of physical therapy services eligible for Medical Assistance reimbursement are provided recipients who are also eligible for Medicare. 20-Day Response to Public Comments, p. 3.

18. The Administrative Law Judge finds that the amendment to Part 9505.5220, subp. 2,

19. The Legal Services Advocacy Project, at the hearing and in its comments of March 23, 1994, at p. 2, stated that Part 9505.5220, subp. 3 impermissibly narrows the requirement of Minn. Stat. § 256B.0644 (1993), which states that the provider must either accept new Medical Assistance, General Assistance Medical Care and MinnesotaCare patients or "at least 20% of the provider's patients are covered by Medical Assistance, General Assistance medical care and MinnesotaCare as their primary source of coverage." Subpart 3, it is argued, calculates the 20% on the basis of active patient case load and "patient encounters that result in a billing". The Advocacy Project is concerned that a provider could manipulate the delivery of services to create more billable encounters in order to reduce the number of new public assistance recipients that the provider is required to serve. In its Statement of Need and Reasonableness, Dept. Ex. 3, at p. 8, the Agency stated why it uses a "patient encounters that result in a billing" standard rather than simple numbers of patients. It is the position of the Advisory Committee, adopted by the Agency, that many recipients require more health care services and time than patients covered under other insurance plans and they are, therefore, more expensive to serve. Basing the calculation on billing encounters, as opposed to simple patient numbers, evens out the greater costs of serving persons likely to be greater users of health care services. Further, requiring the encounter to result in a billing eliminates superficial or brief patient contacts and ensures that a patient contact actually constitutes a health service as evidenced by a billing record. The Administrative Law Judge finds that the Agency has demonstrated the need for and reasonableness of Part 9505.5220, subp. 3 by an affirmative presentation of fact. An agency may demonstrate the reasonableness of its proposed rule by showing that the rule is rationally related to the end sought to be achieved. *Blocher Outdoor Advertising Co. v. Minnesota Department of Transportation*, 347 N.W.2d 88 (Minn.

App. 1984). An agency is entitled to choose among possible alternative standards, so long as the choice is a rational one. If commentators suggest alternative standards, it is not the role of the Administrative Law Judge to determine which alternative is the "best".

20. Part 9505.5220, subp. 4 relates to the granting of waivers from this part. Most of the commentators that had supported the amendment to subpart 2 of this part described in Finding 17, supra, also suggested, in the alternative, a waiver provision designed to remove the difficulty that independently-owned occupational therapists and physical therapists would face. Their suggestions for an expanded waiver section were adequately answered by the Department in proposing the addition of item C to subpart 2 of this part. See, Finding 17, supra.

21. The Legal Services Advocacy Project suggested that the waiver provision contained in subpart 4 be clarified to provide that the length of a waiver granted should be coextensive with the length of time that the provider states it is not going to accept new patients, with a maximum waiver length of one year. The Legal Services Advocacy Project, at p. 3 of its comments of March 23, 1994, suggested specific language to accomplish the clarification. The Department, in its 20-Day Response to Public Comments, agreed that the length of the waiver should be coextensive with the time within which a provider does not accept new patients, with a maximum waiver length of one year. It proposed to amend subpart 4 of this part by striking the word "annually" in the third line of subpart 4 of this part, by adding the phrase "for up to one year" after the word "waiver" in line 5 of this subpart, and by striking the phrase "for one year" in line 7 of the Revisor's draft, at page 5. The Administrative Law Judge finds that the amendment is needed and reasonable because the proposed rule but only clarifies the original intention in response to public comments.

22. As a consequence of Findings 13-21, supra, the Agency has demonstrated that Part 9505.5220, as amended, is needed and reasonable and the amendments do not constitute a prohibited substantial change.

Part\_9505.5230: \_\_Conditions\_of\_Participation;\_Health\_Maintenance Organization.

23. Part 9550.5230 relates to participation by Health Maintenance Organizations (HMOs) in Department Health Care Programs. Subpart 1 of this part initially requires that a health maintenance organization participate in each Department Health Care Program within its approved service area. Blue Cross/Blue Shield and Blue Plus of Minnesota, in its comments of March 22, 1994, state that it would be more appropriate and responsive to local conditions and to HMO costs to allow a health maintenance organization to determine whether to participate in a particular program on a county-by-county basis. The Department, in its 20-Day Response to Public Comments, at p. 3, rejected the argument of Blue Cross/Blue Shield. Minn. Stat. § 256B.0644 (1993), requires participation "in the Medical Assistance program, General Assistance medical care program, and MinnesotaCare . . . ." The Administrative Law Judge agrees with the Department that use of the conjunctive "and" clearly indicates a legislative intent that providers and health maintenance organizations be willing to accept patients from all three programs. It is, therefore, consistent with the statute to require participation in all three programs in an area where the HMO is licensed. Also, as the Department notes in its 20-Day Response to Public Comments at p. 3, all of the separate programs will be consolidated by July of 1997. The Administrative Law Judge finds that the Agency has demonstrated the need for and reasonableness of requiring a health maintenance organization to participate in each Department Health Care Program within its approved service area.

24. Part 9505.5230, subp. 1A(2) requires a health maintenance organization to submit a response to a department request for proposal to contract as a health plan if the HMO is licensed for a service area that includes all or part of the geographic area in the request for proposal and is currently under contract with the Department to provide health services under a mandatory health program in a geographic area identified in the request for proposal. A number of commentators argued that subpart 1A(2), as drafted,

would have an unfair effect on HMOs. Health Partners, in its comments of March 23, 1994, states that requiring a response to a request for proposal by an HMO currently providing services under a mandatory health program, whether or not it has met its participation threshold, violates principles of fairness and flexibility. UCare Minnesota, in its comments of March 21, 1994, at page 1, states that the requirement of Part 9505.5230, subp. 1A(2) places an unreasonable demand on an HMO to continue to do business in an area regardless of any changes to the market or organizational changes within an HMO. Medica, in its comments of March 3, 1994, argues that an HMO that currently contracts with DHS under the proposed rule must continue to contract in the contracted service area, regardless of whether the HMO has met its participation threshold. Medica gives a number of reasons for the limitation being considered unreasonable. Finally, Blue Cross/Blue Shield of Minnesota, in its comments of March 18, 1994, argues that the provision of the proposed rule over-regulates where an HMO has met its requirement for participation.

The Department, in its 20-Day Response to Public Comments, recognized the arguments of Blue Cross/Blue Shield, UCare Minnesota, Medica and Health Partners, by suggesting the following amendment to Part 9505.5230, subp. 1A(2), after the word "proposals" in line 32 of item A(2) before the period, add the following language: "and will

25. Part 9505.5230, subp. 1B initially required an HMO that had to respond to a request for proposal under item A of the same subpart to meet the requirements in the request for proposal. The proposed rule contained no limitation on the contents of the request for proposal. At the hearing, a number of public witnesses argued that the Department should be limited in the content of its request for proposal by the authorizations contained in statutes and rules for health plan contracts. It should not have virtually absolute freedom to include any requirement in a request for proposal. The following commentators also made the same statement in their written submissions: Blue Cross/Blue Shield Blue Plus of Minnesota; Health Partners; and UCare Minnesota.

In its 20-Day Response to Public Comments, the Department agreed that it would be appropriate to limit the mandatory contents of the request for proposal to the requirements authorized by statute or governing rule. It proposed the following amendment to subpart 1, item B: In line 2 of item B, strike the following: "the requirements in". After the word "proposals" in line 3 of item B and before the period insert "requirements authorized in statute and rule for health plan contracts". See, 20-Day Response to Public Comments, pp. 5-6.

The Administrative Law Judge finds that the rule, as amended, is needed and reasonable. The amendment clarifies that the content of a Department request for proposal is governed by statute and rule and, at the same time, allows for a measure of flexibility in contract negotiation. Because the change is merely a clarifying amendment which is declarative of existing law, it is not a prohibited substantial change within the meaning of Minn. Stat. §14.15, subd. 3 (1993) and Minn. Rules, pt. 1400.1000, subp. 1 (1991) and pt. 1400.1100 (1991).

26. Part 9505.5230, subp. 1, item C requires that an HMO in a geographic area be notified by the Commissioner if it will be required to respond to the RFP. UCare Minnesota, in its comments of March 21, 1994, stated that the subpart should be amended to explain how the Commissioner would determine which HMOs should respond to an RFP. UCare Minnesota believed that such language was necessary to ensure uniformity in the application of the rule and to avoid bias or inconsistency. In its 20-Day Response to Public Comments, at p. 5, the Department pointed out that the criteria for determining whether an HMO must respond to an RFP are stated in Part 9505.5230, subp. 1, item A, as amended. Therefore, no additional criteria need be stated. The Administrative Law Judge agrees with the Department. The Agency has demonstrated the need for and reasonableness of item C by an affirmative presentation of fact in the record.

27. No adverse oral or written public comments were received with respect

to subparts 2 and 3 of Part 9505.5230. The need for and reasonableness of these subparts is demonstrated in the SONAR. The Administrative Law Judge, therefore, finds that subparts 2 and 3 of Part 9505.5230 have been demonstrated to be both needed and reasonable.

28. Subpart 4 of Part 9505.5230 relates to HMO subcontracts with other HMOs. The provision, as initially published, provided that when a health maintenance organization subcontracted all or a portion of its provider network to another HMO, only one HMO, as designated by the contracting HMOs, could count the enrolled recipients for purposes of compliance with Part 9505.5230. Medica, in its comments of March 3, 1994, at p. 6, stated that the provision would allow an HMO to subcontract with an "exempt HMO" and count its recipients for purposes of compliance. The Department accepted the suggestion of Medica and proposed the following amendment to subpart 4: in line 23, after the title of the subpart, insert "A. Except as provided in items A and B," and change "If" to "if"; and after line 27, add the following item:

B. If at least 75 percent of a

20-Day Response to Public Comments, p. 5.

The amendment to subpart 4 is needed and reasonable. This clarification is needed and reasonable to ensure that an HMO with minimal recipient enrollment does not evade the rule through a subcontract that allows it to count the enrolled recipients of an HMO that serves only recipients. The 75% figure is consistent with federal requirements contained in 42 C.F.R. 434.26(a). The Administrative Law Judge, therefore, finds that subpart 4A and 4B of this part, as amended, are needed and reasonable. The amendment does not constitute a prohibited substantial change. It does not enlarge the application of the rule. It is merely a clarification to avoid an evasion of the rule.

29. Health Partners, in its comments of March 23, 1994, March 11, 1994 and March 30, 1994 proposed changes to subpart 4 which would allow multiple

HMOs jointly offering a PMAP to count recipients on a proportionate basis, rather than allocating recipients only to one. It is the opinion of that commentator that allowing a proportionate counting of recipients would result in facilitating greater cooperation, flexibility and continuity of care. In its 20-Day Response to Public Comments, at pp. 5-6, the Department proposed adding an item C to subpart 4 after line 27 in the Revisor's draft as follows:

C. Two or more health maintenance organizations that have entered into a written agreement to jointly contract as a single health plan with the department may request a waiver from item A to proportionately count enrolled recipients for purposes for compliance with this part. The commissioner shall grant a waiver permitting each HMO to count a percentage of recipient enrollees for the term of the health plan contract if proportionate counting has the same effect on recipient access to health services as an allocation under item A.

Health Partners, in response to the Department's filing, stated that the amendment proposed by the Department accomplished the results desired by Health Partners and NWNL. It accomplished the goal of allowing greater cooperation, flexibility and continuity of care, as did the language suggested by the health plans. The Administrative Law Judge finds that the addition of an item C, as stated in this Finding, is needed and reasonable for the reasons stated by Health Partners, NWNL and the Department. The Department is authorized to grant rule variances under Minn. Stat. § 14.05, subd. 4 (1993). Moreover, the waiver language contains an appropriate standard for the granting of the waiver. The amendment is not a substantial change because the waiver would not allow duplicate counting of recipients and would be granted only if there were no adverse impact on recipient access to health services.

30. In its March 30, 1994 response to the Department's comments, Health Partners requested that item C of subpart 4 described above be further amended as follows by adding the following language at the end of subpart 4:

In any county in which such an arrangement is in place, each HMO

participating in the arrangement shall be considered a participant in the applicable department program and need not submit an additional request for proposal.

The Administrative Law Judge does not require the Department, as a condition of finding need for and reasonableness of this item to adopt the suggestion of Health Partners. The Department should, however, consider the propriety of the suggested amendment. It may have been overlooked by the Department because of clerical errors in the transmission of the proposed amendment by Health Partners. If the Department adopts the suggested amendment, the amendment would only be a clarifying amendment and would not constitute a prohibited substantial change within the meaning of Minn. Stat. § 14.50, subd. 3 (1993) and Minn. Rules, pt. 1400.1000, subp. 1

31. Part 9505.5230, subp. 5 relates to a licensed health maintenance organization that is a controlling organization. The subpart requires the controlling organization to comply using the combined market share of its related health maintenance organizations to calculate the proportion of market share. Health Partners, in its comments of March 23, 1994, argues that the second clause of the subpart should be revised by deleting the word "must" and inserting "has the option to". The Department, in its 20-Day Response to Public Comments, declined to accept the suggestion of Health Partners. The Department stated in the Statement of Need and Reasonableness, its reasons for declining to give an option. The Administrative Law Judge accepts the reasoning of the Department. The Department has demonstrated the need for and reasonableness of proposed rule Part 9505.5230, subp. 5 by an affirmative presentation of fact in the record.

32. Subpart 6 of Part 9505.5230 allows an HMO in a geographic area to limit its enrollment of recipients to 55% of the total number of recipients enrolled in the geographic area if three or more health plans are under contract with the Department in a specific geographic area. Health Partners, in its comments of March 23, 1993, requested an amendment to the subpart that would provide that a health plan be allowed to limit its enrollment of

recipients to less than 55% of the total number of recipients enrolled in the geographic area if it demonstrates that it is not able to contract with sufficient additional providers and that under its current provider capacity additional enrollment would result in decreased access and quality of care. In its reply comments, the Department declined to adopt the language proposed by Health Partners, stating that the 55% limitation applies only to health plans that have met Department requirements and are under contract and that the 55% limitation is entirely permissive. The Department suggests that if access and capacity are problems for an HMO, it is most appropriate to address those issues in the response to request for proposal and the contract process.

Blue Cross/Blue Shield, in its comments of March 18, 1994, at p. 4, argues that subpart 6, although permissive in statement, implies that if there are fewer than three HMOs, no limit will be allowed and that at no time will a limit less than 55% of recipients be allowed. The Department, in its 20-Day Response to Public Comments, at p. 6, recognizes the comments of Blue Cross/Blue Shield and states the following:

The Department declines to change this subpart, believing that the plain language of the subpart does not state nor imply that HMOs must accept up to 55 percent of recipients in an area. Subpart 6, as the heading states, simply allows a 55 percent recipient enrollment limitation under the specified circumstances: i.e., when three or more health plans are under contract with the Department in an area, none of the contracting HMOs will be required to serve more than 55 percent of recipients. The 55 percent limitation does not apply to the RFP process which defines participation (subpart 1).

The Administrative Law Judge recognizes the concern of Blue Cross/Blue Shield, as stated in its comments. It is clear, however, that the Department did not mean to imply the conclusions suggested by Blue Cross/Blue Shield. The Administrative Law Judge has, therefore, perpetuated the response of the Department in this Finding as a clear statement of intent by the Department and

the Department's construction of the meaning of subpart 6. The Administrative Law Judge accepts this construction by the Department. He finds that the part is needed and reasonable, as proposed by the Department, if its construction of the rule, as stated above, is followed and at no later time does it attempt to draw the implications discussed by Blue

33. Subpart 7 of Part 9505.5230, as proposed, authorized an HMO initially contracting in an area to provide recipients a network different from state health plan networks. Blue Cross/Blue Shield, Medica, UCare Minnesota and Health Partners suggested deleting subpart 7 because, in their minds, it would have a negative effect on the ability of HMOs to design freely appropriate networks, critical to meeting the needs of recipients. In its 20-Day Response to Public Comments, the Department proposed to delete subpart 7 in its entirety. As stated by the Department, deleting subpart 7 would not have a critical impact on the proposed rules. The subpart was only permissive and deleting the subpart does not prevent an HMO from doing precisely what was provided for in the subpart. Further, the Department will be able to assure a qualified network of providers for recipients through the RFP and contract process. The deletion of subpart 7 is not a substantial change within the meaning Minn. Stat. § 14.15, subd. 3 (1993) and Minn. Rules, pt. 1400.1000, subp. 1 (1991) and pt. 1400.1100 (1991).

Part\_9505.5240: \_\_Report;\_Exclusion\_from\_Participation

34. Part 9505.5240 relates to quarterly reports to state agencies, findings of non-compliance and exclusion from participating in state health care programs as listed in Part 9505.5210, subp. 14. Medica, in its comments of March 3, 1994, requested amendments to subparts 2 and 3 to clarify the effect and consequences of noncompliance. Some of the changes suggested by Medica in its comments of March 3, 1994, were meant to secure more due process before a provider was removed from the quarterly compliance list. In response

to the suggestion of Medica, the Department, in its 20-Day Response to Public Comments, at p. 7, proposed the following amendment to subpart 3:

Subp. 3. Exclusion for Noncompliance.

The\_Commissioner\_shall\_consider\_evidence\_provided\_in\_response\_to a\_notice\_of\_alleged\_noncompliance. Within 30 days after receiving evidence provided in response to a notice of alleged noncompliance, the Commissioner shall notify the provider or health maintenance organization whether compliance has been demonstrated. If\_no\_evidence\_was\_submitted\_within\_30\_days\_of the\_notice\_under\_subpart\_2,\_or\_the\_Commissioner\_determines\_the provider\_or\_HMO\_is\_not\_in\_compliance, the Commissioner shall remove the provider or HMO from the list of participating providers and HMOs in the next subsequent quarterly report a provider or HMO that is not in compliance with parts 9505.5200 to 9505.5240.

35. The Administrative Law Judge finds that the Department has demonstrated the need for and reasonableness of subpart 2 and subpart 3 as amended. The clarifications suggested by Medica merely require either a default or a specific determination by the Commissioner upon evidence submitted before a participating provider is eliminated from participation. As such, due process is afforded. The change is really required by principles of equity and fairness, and does not enlarge the application of the proposed rules. It is not, therefore, a prohibited substantial change within the meaning of Minn. Stat. § 14.15, subd. 3 (1993) and Minn. Rules, pt. 1400.1000, subp. 1 (1991) and Part 1400.1100 (1991).

36. Medica, also in its comments of March 3, 1994, at p. 5, requests the addition of a specific provision that HMOs that are removed from the quarterly report shall not be eligible for reimbursement under any Department or other state health care program. UCare Minnesota, in its comments of March 21, 1994, also suggested that language be added to this subpart about the effect on enrollees of a provider or HMO that is excluded from participation. The Department, at p. 7 of its 20-Day Response to Public Comments, declined to accept either the suggestion of UCare Minnesota or Medica, on the gr

37. Blue Cross/Blue Shield, in their comments of March 18, 1994,

suggested that the Department track noncompliance instead of compliance. It requested that the Department provide a list of vendors who are not in compliance. The Agency, in its 20-Day Response to Public Comments, at p. 7, states that Minn. Stat. § 256B.0644 (1993), clearly directs the Commissioner to provide lists of participating providers. The Department has no means to track nonparticipating vendors. The Department appropriately rejected this suggestion by Blue Cross/Blue Shield.

38. As a result of Findings 34-37, supra, the Department has demonstrated the need for and reasonableness of Part 9505.5240, as amended, by an affirmative presentation of fact. The changes to of Part 9505.5240 proposed by the Department do not constitute prohibited substantial changes.

39. Several commentators suggested additions to the rules. Health Partners, in its comments of March 23, 1994, at p. 4, suggested the addition of a new subpart to Part 9505.5220, pertaining to vendor participation as follows:

In counties where the state has mandated services be provided through PMAP contracts, providers within the county must still meet requirement of subpart 1.

This comment was designed to illustrate Health Partner's concern that there needs to be a link between the vendor participation requirements and the HMO requirements in order to carry out effectively the intent of the rule. Without some link, an HMO may be in a situation where it has to fulfill service requirements, but may not be able to secure provider contracts to fulfill those requirements. For reasons stated by the Department in its 20-Day Response to Public Comments, the Administrative Law Judge does not find the suggested addition to be necessary.

40. Medica, in its comments of March 3, 1994, stated that participation calculations should include enrollees a HMO may serve through HMO-affiliate, self-insured product lines. Blue Cross/Blue Shield of Minnesota, at page 5 of its Comments of March 18, 1994, provides reasons why the comment of Medica should not be accepted. The Department, in its 20-Day Response to Public Comments, also declined to accept the Medica suggestion. The HMO participation

requirements authorized under Minn. Stat. § 256B.0644 (1993), that are the subject of the rules, do not apply to self-insured affiliates, which are not HMOs licensed under Minnesota Statutes, c. 62D (1993). For the reasons relied upon by the Department at page 8 of its 20-Day Response to Public Comments, the Administrative Law Judge does not find the suggested addition to be necessary.

Based upon the foregoing Findings of Fact, the Administrative Law Judge makes the following:

#### CONCLUSIONS

1. The Agency gave proper notice of the hearing in this matter.
2. The Agency has fulfilled the procedural requirements of Minn. Stat. § 14.14, and all other procedural requirements of law or rule.
3. The Agency has documented its statutory authority to adopt the proposed rules, and has fulfilled all other substantive requirements of law or rule within the meaning of Minn. Stat. §§ 14.05, subd. 1, 14.15, subd. 3 and 14.50 (i) and (ii).
4. The Agency has demonstrated the need for and reasonableness of the proposed rules by an affirmative presentation of facts in the record within the meaning of Minn. Stat. §§ 14.14, subd. 2 and 14.50 (iii).
5. The additions and amendments to the proposed rules which were suggested by the Agency after publication of the proposed rules in the State Register do not result in rules which are substantially different from the proposed rules as published in the State Register within the meaning of Minn. Stat. § 14.15, subd. 3, Minn. Rule 1400.1000, Subp. 1 and 1400.1100.
6. Any Findings which might properly be termed Conclusions and any Conclusions which might properly be termed Fi
7. A finding or conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the

Agency from further modification of the rules based upon an examination of the public comments, provided that no substantial change is made from the proposed rules as originally published, and provided that the rule finally adopted is based upon facts appearing in this rule hearing record.

Based upon the foregoing Conclusions, the Administrative Law Judge makes the following:

RECOMMENDATION

IT IS HEREBY RECOMMENDED: that the proposed rules, as amended, be adopted consistent with the Findings and Conclusions made above.

Dated this 5th\_ day of May, 1994.

\_s/\_Bruce\_D.\_Campbell\_\_\_\_\_

BRUCE D. CAMPBELL  
Administrative Law Judge

Reported: Audio-Magnetic Record; No Transcript Prepared.