

STATE OF MINNESOTA
OFFICE OF ADMINISTRATIVE HEARINGS

FOR THE MINNESOTA DEPARTMENT OF HUMAN SERVICES

In the Matter of Proposed Adoption
of Amendments to Rules of the
Department of Human Services
Governing MinnesotaCare,
Minnesota Rules, Parts 9506.0010
to 9506.0400.

REPORT OF THE
ADMINISTRATIVE LAW JUDGE

The above-entitled matter came on for hearing before Administrative Law Judge Allen E. Giles on May 4, 1995, at 9:30 a.m. in the Office of Aeronautics Building, 222 East Plato Boulevard, St. Paul, Minnesota.

This Report is part of a rulemaking proceeding held pursuant to Minn. Stat. §§ 14.131 to 14.20, to hear public comment, determine whether the Minnesota Department of Human Services ("DHS" or "the Department") has fulfilled all relevant substantive and procedural requirements of law or rule applicable to the adoption of the rules, evaluate whether the proposed rules are needed and reasonable, and assess whether or not modifications to the rules proposed by the Department after initial publication are substantially different from the rules as originally proposed.

Patricia Sonnenberg, Assistant Attorney General, 1200 NCL Tower, 445 Minnesota Street, St. Paul, Minnesota 55101-2130, appeared on behalf of the Department at the hearing. The Department's hearing panel consisted of Martha N. O'Toole, Rules Coordinator of the Appeals and Regulations Division at DHS; Patricia McTaggart, Director of the Health Care Delivery Division; Jim Chase, Director of the Managed Care Division; Cynthia McDonald, Contracts Manager of the Federal Relations Division; Paul Olson, Director of the Payment Policy Division; and Kathy Lamp, Director of the MinnesotaCare Division.

Fourteen persons attended the hearing. Thirteen persons signed the hearing register. The Administrative Law Judge ("ALJ" or "the Judge") received thirteen agency exhibits and two public exhibits during the hearing. The hearing continued until all interested persons, groups, and associations had an opportunity to be heard concerning the adoption of these rules.

The record remained open for the submission of written comments until May 24, 1995, twenty calendar days following the date of the hearing. Pursuant to Minn. Stat. § 14.15, subd. 1 (1992), five working days were allowed for the

filing of responsive comments. At the close of business on June 1, 1995, the rulemaking record closed for all purposes.

The Department must wait at least five working days before it takes any final action on the rule; during that period, this Report must be made available to all interested persons upon request.

Pursuant to the provisions of Minn. Stat. § 14.15, subds. 3 and 4, this Report has been submitted to the Chief Administrative Law Judge for his approval. If the Chief Administrative Law Judge approves the adverse findings of this Report, he will advise the Department of actions which will correct the defects and the Department may not adopt the rule until the Chief Administrative Law Judge determines that the defects have been corrected. However, in those instances where the Chief Administrative Law Judge identifies defects which relate to the issues of need or reasonableness, the Department may either adopt the Chief Administrative Law Judge's suggested actions to cure the defects or, in the alternative, if the Department does not elect to adopt the suggested actions, it must submit the proposed rule to the Legislative Commission to Review Administrative Rules for the Commission's advice and comment.

If the Department elects to adopt the suggested actions of the Chief Administrative Law Judge and makes no other changes and the Chief Administrative Law Judge determines that the defects have been corrected, then the Department may proceed to adopt the rule and submit it to the Revisor of Statutes for a review of the form. If the Department makes changes in the rule other than those suggested by the Administrative Law Judge and Chief Administrative Law Judge, then it shall submit the rule, with the complete hearing record, to the Chief Administrative Law Judge for a review of the changes before adopting it and submitting it to the Revisor of Statutes.

When the Department files the rules with the Secretary of State, it shall give notice on the day of filing to all persons who requested that they be informed of the filing.

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

FINDINGS OF FACT

Nature of the Proposed Rules and Statutory Authority

1. In 1992, the Minnesota Legislature enacted the HealthRight Act (Minn. Laws 1992 ch. 549), establishing a program of subsidized health coverage for uninsured Minnesota residents. Subsequently, named MinnesotaCare, the program is administered by the Department of Human Services.

2. MinnesotaCare is a program of subsidized health care insurance intended to provide health care to persons who otherwise would have no health

care coverage. In 1993, the Legislature directed the Commissioner of Human Services to use managed health care plans to provide health care to MinnesotaCare enrollees. The Commissioner is authorized to “adopt rules to administer the MinnesotaCare program”. Minn. Stat. § 256.9352, subd. 2 1994).

3. The proposed rules are intended to implement managed care for MinnesotaCare enrollees. The proposed rules define terms, set eligibility standards, establish application requirements, set standards for coverage periods, set premium amounts, establish the calculation for determining income levels, coordinate MinnesotaCare and Medical Assistance, establish quality controls, incorporate an appeal process, identify covered health services, and require copayments.

4. The Judge finds that the Department has general statutory authority to adopt these rules.

Procedural Requirements

5. On June 27, 1994, the Department published a Notice of Solicitation of Outside Opinion at 18 State Register 2758 regarding its proposal to adopt rules governing MinnesotaCare.

6. On February 24, 1995, the Department 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. the Statement of Need and Reasonableness (“SONAR”);
- e. a fiscal note;
- f. a statement by the Department of the anticipated duration and attendance at the hearing; and
- g. a notice of discretionary additional public notice pursuant to Minn. Stat. §14.14, subd. 1a.

7. On March 14, 1995, the Department mailed the Notice of Hearing and a copy of the proposed rule to all persons and associations who had registered their names with the Department for the purpose of receiving such notice, all persons who requested a hearing on these rules, and all persons to whom additional discretionary notice was given by the Department.

8. On March 20, 1995, the Department published the Notice of Hearing and the proposed rules at 19 State Register 1945.

9. On April 6, 1995, the Department filed the following documents with the Administrative Law Judge:

- a. a photocopy of the pages of the State Register containing the Notice of Hearing and the proposed rules;
- b. the Notice of Hearing as mailed;
- c. the Department's certification that its mailing list was accurate and complete as of March 14, and the Affidavit of Mailing the Notice to all persons on the Department's mailing list;
- d. the Affidavit of Mailing the Notice to those persons to whom the Department gave discretionary notice;
- e. a statement that no materials were received in response to the Notice of Solicitation of Outside Opinion published on June 27, 1994; and
- f. the names of Agency personnel or others solicited by it to appear.

Impact on Agricultural Land

10. Minn. Stat. § 14.11, subd. 2 imposes additional statutory requirements when rules are proposed that have a "direct and substantial adverse impact on agricultural land in this state." The statutory requirements referred to are found in Minn. Stat. §§ 17.80 to 17.84. The rules proposed by the Department will have no substantial adverse impact on agricultural land within the meaning of Minn. Stat. § 14.11, subd. 2.

Fiscal Note

11. Minn. Stat. § 14.11, subd. 1, requires state agencies proposing rules that will require the expenditure of public funds in excess of \$100,000 per year by local public bodies to publish an estimate of the total cost to local public bodies for the two years immediately following adoption of the rules. DHS has prepared a fiscal note estimating that the rule will impose no costs on local public bodies in either of the first two years. DHS noted that some costs will be incurred by the state to implement these rules. Those costs were identified in a legislative fiscal note. The Department has met the requirements for preparing a fiscal note.

Small Business Considerations in Rulemaking

12. Minn. Stat. § 14.115, subd. 2 requires state agencies proposing rules that may affect small businesses to consider methods for reducing adverse

impact on those businesses. In its SONAR and Notice of Hearing, the Department indicated that these rules fall within the exemption for rules that cover “service businesses regulated by government bodies for standards and costs.” Minn. Stat. § 14.115, subd. 7(3). The Department regulates both standards and costs for the MinnesotaCare program. An analysis of small business considerations is not required under Minn. Stat. § 14.115, subd. 2, for these rules.

Reasonableness of the Proposed Rules

13. The Administrative Law Judge must determine, inter alia, whether the need for and reasonableness of the proposed rules have been established by the Department by an affirmative presentation of facts. Minn. Stat. § 14.14, subd. 2. The question of whether a rule is reasonable focuses on whether it has a rational basis. The Minnesota Court of Appeals has held a rule to be reasonable if it is rationally related to the end sought to be achieved by the statute. Broen Memorial Home v. Minnesota Department of Human Services, 364 N.W.2d 436, 440 (Minn. App. 1985); Blocher Outdoor Advertising Company v. Minnesota Department of Transportation, 347 N.W.2d 88, 91 (Minn. App. 1984). The Supreme Court of Minnesota has further defined the burden by requiring that the agency “explain on what evidence it is relying and how the evidence connects rationally with the agency's choice of action to be taken.” Manufactured Housing Institute v. Pettersen, 347 N.W.2d 238, 244 (Minn. 1984). An agency is entitled to make choices between possible standards as long as the choice it makes is rational. If commentators suggest approaches other than that selected by the agency, it is not the proper role of the Administrative Law Judge to determine which alternative presents the “best” approach.

14. The Department prepared a Statement of Need and Reasonableness (“SONAR”) in support of adoption of the proposed rules. At the hearing, the Department primarily relied upon the SONAR as its affirmative presentation of need and reasonableness for each provision. The SONAR was supplemented by the comments made by the Department at the public hearing and in its written post-hearing comments.

15. The Findings in this Report do not address each part of the proposed rules, rather the Findings primarily address those parts that received public commentary or for which changes have been made since publication in the State Register. After careful review and consideration of the Department’s Statement of Need and Reasonableness and based upon the Department’s oral presentation at the hearing and comments submitted after the hearing, the Administrative Law Judge finds that the Department has affirmatively established the need and reasonableness of each part of the proposed rule except as otherwise qualified or determined by the following Findings and Conclusions.

16. Where changes are made to the rule after publication in the State Register, the Administrative Law Judge must determine if the new language is

substantially different from that which was originally proposed. Minn. Stat. § 14.15, subd. 3 (1992). The standards to determine if the new language is substantially different are found in Minn. Rules Part 1400.1100. Upon consideration of the changes proposed by the Department and discussed later in this Report, the Administrative Law Judge finds that each of the proposed changes is needed and reasonable and does not constitute a substantial change.

ANALYSIS OF RULE PARTS GENERATING SIGNIFICANT PUBLIC COMMENTARY

Proposed Rule Part 9506.0010 - Definitions

17. Proposed rule 9506.0010 defines four terms used in the MinnesotaCare program. Only those terms that received comment or otherwise need examination will be discussed in this Report. The remaining definitions are found to be needed and reasonable.

Subpart 13a - Managed Care Health Plan or Health Plan

18. Subpart 13a defines “managed care health plan” or “health plan,” for the purpose of the MinnesotaCare rules, to mean medical care vendors who contract with the Department on a capitation basis to provide health care services to MinnesotaCare enrollees. Metropolitan Health Plan (MHP) is a health maintenance organization (HMO) formed under the auspices of Hennepin County. Joan Delich, Director of Administrative Services for MHP, criticized subpart 13a for failing to set standards as to what health plans qualify for contracting with the Department for providing services to enrollees. Ghita Worcester, on behalf of the Minnesota Council of HMOs, suggested that enrollees are inadequately protected when the Department contracts with vendors who do not meet the Department of Health standards for HMOs, integrated service networks (ISNs), or community integrated service networks (CISNs). The Minnesota Council of HMOs suggested a requirement that the definition in subpart 13a include that vendors must meet the financial reserve requirements of HMOs, ISNs, or CISNs.

19. Suzanne M. Veenhuis, on behalf of the Minnesota Medical Association (MMA), pointed out that the Department is statutorily required to evaluate vendors under Minn. Stat. § 256.9363, subd. 7(7), for financial capacity to provide health care service to enrollees. MMA also noted that a work group of the Recodification Advisory Task Force (a collaborative group working with DHS) is considering a risk-based capital formula to assess the required level of net worth for providers. Such a formula would require different levels of financial assurance for different providers.

20. The Department pointed out that Minn. Stat. § 256.9363, subd. 1 lists a variety of vendors that are eligible to contract with the Department to provide services to enrollees. Department Comment, at 1. Placing a limitation on eligible

providers would be contrary to the statute and would result in a defect in the proposed rule. The Department is required by law to evaluate the financial capacity of potential vendors. This requirement is adequate to protect the interests of enrollees.

21. Deborah Glass, Vice President of Government Programs for Blue Cross/Blue Shield of Minnesota (BCBS) objected to the inclusion of “competitive bidding programs” in the definition of “managed care health plan” or “health plan” since such programs are not defined in statute or rule. DHS responded that the term is in the statute (Minn. Stat. § 256.9363, subd. 1) and to not include such programs would conflict with the statute. DHS is correct. While a definition in the rule of “competitive bidding program” would be preferable, the rule is not defective for omitting such a definition. Excluding such programs would conflict with the statute and constitute a defect in the proposed rule.

22. The last sentence of the subpart purports to list examples of managed care health plans. The proposed exemplary language is inappropriate in a rule. Examples do not create or define a classification and, therefore, are more akin to hypotheticals. The exemplary language is not a rule and, therefore, should be excluded. This language is not a rule and therefore is not necessary.

23. To cure this defect, the Department can delete the last sentence or replace “Examples of managed health care plans include” with “Among managed health care plans are ...” The suggested language acts as a definition by placing the listed entities within the definition of “managed health care plans.” Subpart 13a is needed and reasonable, as modified. The new language does not constitute a substantial change.

Subpart 17a - Participating Provider

24. Subpart 17a defines “participating provider” as someone “employed by or under contract with a health plan to provide health services to enrollees.” M. Francesca Chervenak, an attorney with the Legal Aid Society of Minneapolis (Legal Aid), objected to the lack of standards or requirements regarding participating providers. Legal Aid suggested that the standards in the Prepaid Medical Assistance Program (PMAP) be incorporated to ensure that quality services are provided to enrollees. Legal Aid Comment, at 2. The Department responded that MinnesotaCare is following a private insurance model of health care coverage, not a medical assistance model. This means that the obligation of maintaining quality assurance is on the health plan, the Department of Health, and various professional licensing boards, not DHS. That is currently the situation for all members of those health plans not enrolled in MinnesotaCare. The choice of approach is within the agency’s discretion. Subpart 17a is needed and reasonable, as proposed.

Subpart 18a - Risk Contract

25. Subpart 18a defines “risk contract” as “a contract between the department and a managed care health plan under which the health plan may incur a financial loss because the cost the health plan incurs providing inpatient hospital services may exceed the capitation payments of the Department. The HMO Council and BCBS suggested adding language to expressly allow for financial gain under these types of contracts. DHS declined to make that change, since the purpose of the rule is to distinguish between guaranteed payments and capitation payments. Capitation payments are identical, per person payments regardless of the services provided. If a health plan keeps its costs of care below the total capitation payments received, the health plan retains the difference as profits. If the costs of care exceed the capitation payments received, the health plan takes a loss. The change to the subpart suggested by the HMO Council does not clarify the rule. DHS did modify the rule to delete any reference to financial loss. This modification was made to delete redundant and unnecessary language from the subpart. Subpart 18a is needed and reasonable as modified. The new language is not a substantial change.

Proposed Rule 9506.0050 - Coordination of MinnesotaCare and Medical Assistance

26. Proposed subpart 5 of Minnesota Rule 9506.0050 requires MinnesotaCare enrollees who become eligible for Medical Assistance (MA) to remain in the same health plan, so long as that plan provides services in the recipient’s geographic area. Legal Aid objected to this provision as unreasonable where a different plan would better serve the recipient’s needs. Public Exhibit 15, at 2. DHS cited Minn. Stat. § 256.9363, subd. 5 as requiring retention of the same plan under those circumstances. The proposed change is contrary to statute and would render the proposed rule defective. Subpart 5 is needed and reasonable as proposed.

Proposed Rule 9506.0200 - Prepaid MinnesotaCare Program; General

27. Under proposed rule 9506.0200, subp. 1, the Commissioner of Human Services designates the geographic areas in which enrollees in MinnesotaCare must be served by a managed care health plan. Item A sets out area size, population size, accessibility of health care, availability of health plans, and “any other factors necessary to provide the most economical care consistent with high medical standards” as the standards to be considered in arriving at that decision. Item C sets out eleven factors the Commissioner must consider in limiting the number of health plans the Department contracts with under the MinnesotaCare program. None of the first ten factors received any comment. The eleventh factor is “any other factors necessary to provide the most economical care consistent with high medical standards. The HMO Council objected to the eleventh factor as “too general.” Public Exhibit 14, at 5. Legal Aid objected to the same language as unnecessary and unreasonable for granting unfettered discretion to the Commissioner in making the decision on limiting health plans. Public Exhibit 15, at 3. Megan Roach, Senior Director of Government Programs for HealthPartners (HealthPartners), suggested that item C(11) could “allow the commissioner to mandate participation when it is not in either the enrollee’s or health plan’s best interest to do so.” HealthPartners Comment, at 2. Ghita Worcester, Director of Operations and Policy for Ucare Minnesota (Ucare), also expressed concern that item C(11) could be used to mandate health plans cover the entire state. Ucare Comment, at 2. Legal Aid suggested deletion of item 11 and retention of the preceding ten factors.

28. The language objected to in this subitem is substantially the same as the language contained in item A, which also contains the language “any other factors necessary to provide the most economical care consistent with high medical standards.” No objections were made to the language as contained in item A. This language is used in both items A and subitem C(11) for the same reason: the Department acknowledges that it cannot identify the universe of factors that constitute “most economical care consistent with high medical standards. Because of rapidly changing developments in health care, the Department would like to have the freedom to consider other factors as the impact of new developments become known. This is a reasonable concern. If the Department did not include subitem C(11), it would have limited means for dealing with circumstances occasioned by new developments in health care.

29. It is reasonable to include subitem C(11). The inclusion will not empower the Commissioner to mandate that a health plan serve a certain area; the purpose of this section is to identify reasons for limiting the plans or programs that the Department contracts with. Subitem C(11) will not place undue discretion in the Commissioner. The Commissioner’s discretion is controlled by “most economical care” and “consistent with high medical standards”. It would be unreasonable to foreclose the Commissioner’s use of these standards for addressing new developments in health care delivery. The language as proposed does not constitute a defect in the proposed rule.

30. The HMO Council and HealthPartners suggested adding language requiring the Commissioner to set out in writing how the factors in item C were applied. The Department declined to add that language, for the reason that such information is available under Minn. Stat. § 16B.09, subd. 4. Department Comment, at 4. Subpart 1 of proposed rule 9506.0200 is needed and reasonable, as proposed.

Subpart 2 - Contracts

31. Item A of subpart 2 requires any health plan under MinnesotaCare to serve MA and General Assistance Medical Care (GAMC) recipients. The HMO Council, MHP, BCBS, and Ucare asserted that the Department lacks the statutory authority to require health plans to serve GAMC recipients. In its SONAR, DHS bases its authority on Minn. Stat. § 256.9363, subd. 5 (1994), which states in pertinent part:

Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may also include general assistance medical care.

This statutory provision was amended in the 1995 Legislative session to read as follows:

Contracts between the department of human services and managed care plans must include MinnesotaCare, and medical assistance and may, at the option of the commissioner of human services, also include general assistance medical care.

Laws of Minnesota 1995, Art. 6, Sec. 15.

32. The Department maintains that requiring health plans under MinnesotaCare to serve GAMC recipients is reasonable, because there is a legislative goal “to eventually integrate the three programs.” This is a policy choice that is within the Department’s discretion. None of the commentators has indicated why serving GAMC recipients is unreasonable. Subpart 2A is statutorily authorized, needed, and reasonable.

33. Subpart 2B requires health plan compliance with the federal statute prohibiting restriction of enrollees for family planning services. DHS added a reference to Minn. Stat. § 62Q.14 which also prohibits restricting access to those services. Subpart 2B is needed and reasonable as modified. The new language is not a substantial change.

Subpart 3 - Multiple Health Plan Model Areas

34. Where contracts have been executed for multiple health plans to provide care, subpart 3 sets out the responsibilities of the Department or an entity under contract with the Department. Legal Aid objected to the possibility of

a contracting entity carrying out the Department's responsibilities. Legal Aid suggested that the rule language was a substantial change from the drafts produced for the working groups on the rule. The commentator also asserted that the rule language was not supported in the SONAR. The Department correctly asserts that where, as here, the proposed language was published in the State Register, that language cannot be a substantial change.

35. In the SONAR, the Department indicates that it will either enroll participants or contract with an entity to do so. SONAR, at 6. DHS points out that Massachusetts and Oregon currently use enrollment contractors. *Id.* In its Comment, the Department indicated that whether staff or a contractor is used is dependent upon subsequent events. Department Comment, at 6. The use of contractors or staff is matter within the agency's discretion. Legal Aid indicates that the use of an outside entity differs from the PMAP system. There is no obligation that the Department use the same approach to different programs. That is particularly true here, where Legal Aid identified a critical difference between MinnesotaCare and PMAP. MinnesotaCare is administered by the Department and PMAP is administered by a local agency (usually a county). DHS indicated that applications will be taken by mail, rather than in-person as is the practice with PMAP. Department Comment, at 6. Under such circumstances, it is difficult to see how the use of an outside entity to process applications creates difficulties. The Department has shown that retaining the option of using an outside entity to enroll participants in MinnesotaCare to be needed and reasonable.

36. Legal Aid urged using the PMAP practice of randomly assigning participants to health plans, when the enrollee has not specified a plan. DHS agreed with the suggestion and modified item B of subpart 3 accordingly. The Department believes, however, that enrollees are likely to specify a health plan under MinnesotaCare, since participants must take affirmative steps to become enrolled. Department Comment, at 8-9. The item is needed and reasonable, as modified. The new language is not a substantial change.

37. The HMO Council suggested adding express authorization for the health plan to assign a primary care provider within the plan where the enrollee has not chosen a primary care provider. DHS declined to do so, stating that assignment of a primary care provider is a matter left to each individual plan. This reply also addressed Legal Aid's suggestion that the Department assign primary care providers where the enrollee declined to do so in a single plan area. Declining to include the suggested language does not render the rule unreasonable.

Subpart 5 - Changing Health Plans or Primary Care Providers

38. An essential part of managed care is retaining a stable population of enrollees that the health plan can rely upon to generate revenue for the plan. To that end, restrictions are placed on the ability of enrollees to change plans. The

most common restriction is limiting the period in which an enrollee can change plans to a once-a-year open enrollment period. This period, usually a month, gives the enrollee time to choose between available health plans on a basis that is frequent enough to meet the legitimate needs of enrollees and infrequent enough to allow health plans to meet the medical needs of their populations. Item A of subpart 5 allows enrollees to change plans once within the first year of participation and after the first year, during the annual open enrollment period.

39. Legal Aid pointed out that the rule did not specify who was to notify enrollees and suggested the PMAP approach be used. Under PMAP, local agencies notify enrollees. The Department adopted similar language to that suggested by Legal Aid, having DHS notify enrollees, and modified that language slightly to allow a contracting entity to conduct the notification. The item is needed and reasonable, as modified. The new language is not a substantial change.

40. Item D of subpart 5 sets out the standards for an enrollee to change plans “for cause,” outside the open enrollment period. As originally proposed, the enrollee could change health plans or primary care provider “at any time” for excessive travel time between the enrollee’s residence and the enrollee’s primary care provider or an incorrect designation of primary care provider or health plan. Legal Aid objected to item D as being more restrictive than Minn. Stat. § 256.9363, subd. 3. Ucare and HealthPartners objected to the “at any time” language and urged the Department to adopt more structured language. Dr. Linda Frizzell supported the free choice of persons living more than thirty miles from a provider to freely change plans or providers.

41. DHS responded by replacing the entire item. The new language requires the enrollee to appeal under part 9506.0070, and allows a change without a hearing, in multiple plan areas, for excessive travel time or incorrect designation due to Department error. The appeal letter in a multiple health plan area would go to the Department. In a single plan area, a change of primary care provider is allowed without a hearing for excessive travel time or error in designation by the health plan. Either the Department or the health plan must decide on the request for a change within thirty days of the appeal, where no hearing is held. The new language conforms the appeal process to that afforded by statute. The exceptions to the appeal process with a hearing are situations where the right to change plans or providers is not likely to be in dispute. Requiring the appeal to be in writing is not an undue burden on enrollees. The modified item D is needed and reasonable. The new language is not a substantial change.

Subpart 6 - Family Participation in a Health Plan

42. Subpart 6 requires that all members of any family enrolled in MinnesotaCare must be members of the same health plan. Legal Aid and the HMO Council supported allowing each family member to choose a different

health plan. DHS supported the subpart as promoting administrative efficiency and supporting all family members receiving consistent care. SONAR, at 7-8. DHS analogized the requirement of the subpart to the requirement that all state employees must choose one health plan for themselves and their families. SONAR, at 8. In its Comment, the Department indicated that it received comments from individuals that the MinnesotaCare program was more attractive when it emulated private insurance, rather than “welfare.” Department Comment, at 13. DHS has shown subpart 6 to be needed and reasonable, as proposed.

Proposed Rule Part 9506.0300 - Health Plan Services; Payment

43. Subpart 1 of proposed rule 9506.0300 requires health plans to provide and pay for the services identified as covered services under Minn. Stat. § 256.9353 and allows health plans to provide nonrequired services. Subpart 2 authorizes the Department to contract on a risk or nonrisk basis with health plans for inpatient hospital services. The HMO Council maintains that the term “nonrisk” is inaccurate because health plans would remain at considerable risk for outpatient services. Public Exhibit 14, at 7. The commentator urged use of more outpatient services to control costs and suggested that nonrisk payments are a disincentive to that approach. The HMO Council asserted that the rule would require unnecessary administrative costs through duplication of the certification process. *Id.* at 8. The commentator urged the Department delete the nonrisk provision from the rule or use fee-for-service payments for inpatient care.

44. DHS responded that nonrisk hospital services are expressly authorized under Minn. Stat. § 256.9363, subd. 9. Department Comment, at 14. The Department expressed its opinion that the Legislature is moving away from fee-for-service toward prepaid capitation as the method of payment for hospital services. As for the certification process, DHS cites Minn. Stat. § 256.9353, subd. 3(c), as requiring all hospital admissions not expressly exempted be certified. The proposed rule reflects the statutory nature of the requirements. Subitem A(2) simply lists the statutes and related rules that must be complied with by health plans arranging inpatient hospital services. The use of prepaid capitation payments is needed and reasonable. The method of certification of admissions set out in the rule is needed and reasonable.

45. The HMO Council urged DHS to delete the pass-through provision of subitem A(3). This provision directs payment from DHS to the health plan, the health plan being responsible for passing-through the payment to the hospital for care received. The HMO Council maintains that pass-through provisions have led to difficulties between health plans and hospitals, including disputes over payment and bookkeeping. Public Exhibit 14, at 8. Pass-through payments are a necessary aspect of prepaid capitation payments and create an incentive for health plans to manage hospitalization costs, rather than use hospitalization as a means of reducing outpatient costs.

46. Mary C. Hipp, Lead Counsel for Medica Government Programs, suggested that subpart 3 be amended to clarify that health plans need not pay for enrollee emergency services from nonparticipating providers or out-of-plan services. DHS responded that the suggested change would deny out-of-plan emergency services to enrollees. The subpart does not impose an unreasonable burden on health plans. The requirement that certain out-of-plan emergency services be paid for by the health plan is consistent with Minn. Stat. § 256B.0625, subd. 4. Under nonrisk contracts, DHS will make pass-through payments for those services to the health plan. The change suggested by Medica could result in enrollees being denied emergency services due to an inability to identify a payor for the costs of those services. This result is antithetical to the purpose of MinnesotaCare, which is to provide insurance-style health care coverage to enrollees. Proposed rule 9506.0300 is needed and reasonable, as proposed.

Proposed Rule Part 9506.0400 - Other Managed Care Health Plan Obligations

47. Subpart 1 of proposed rule 9506.0400 requires health plans to “hold harmless” the State and enrollees for any health plan debts where the plan becomes insolvent. Information must be provided to enrollees about coverage, providers, and the complaint and appeal procedure under subpart 2. As originally proposed, subpart 3 required case management for enrollees without limitation. MHP, UCare, HealthPartners, and BCBS objected to the case management requirement as being an unnecessary expense for most enrollees in MinnesotaCare. Case management services are usually put in place to assist populations that have difficulty accessing proper medical care. The Department has based much of its rules on the self-motivation of enrollees to MinnesotaCare. DHS acknowledged that case management is not necessary for all enrollees and modified subpart 3 to require a health plan to “have available” a system of case management. Since most (if not all) existing health plans have case management available for some of their enrollees, the rule requiring availability is both needed and reasonable. The language change is not a substantial change.

48. Subpart 4 requires that the health plan contract identify information to be submitted to the Department and the Health Care Financing Administration. The subpart also requires a health plan to respond to requests for additional information within thirty days. BCBS and the HMO Council suggested limiting the scope of the subpart to “reasonable requests for information.” Legal Aid opposed any limitation on the scope of information that could be requested. DHS has the responsibility to oversee the MinnesotaCare program and is not required to put language into the rules likely to become a bone of contention. Subpart 4 is needed and reasonable, as proposed.

49. A quality assurance program including internal review, corrective action plan, inspections, customer surveys, and deficiency corrections is required under subpart 5. Legal Aid suggested that the provision on surveys be clarified to require annual surveys. DHS agreed with that proposal and modified the rule

accordingly. Subpart 5 is needed and reasonable, as modified. The change is not a substantial change.

50. Under subpart 8, the financial risk capacity of health plans must either meet the Department of Health standards for HMOs, ISNs, or CISNs, or the plan can demonstrate that its capacity is acceptable to its participating providers. The HMO Council and HealthPartners suggested that the latter standard is too subjective and recommended that the Department of Health standards be met by all health plans. DHS declined to accept this suggestion, citing legislative authorization of a different standard and the need for flexibility to respond to new types of managed care organizations. Department Comment, at 16-17. The Department's standards have been shown to be needed and reasonable.

51. Medica objected to the notification provision in subpart 14. Under that rule, the health plan must notify its enrollees of the termination of the MinnesotaCare contract at least sixty days prior to the termination date. The commentator's objection was that DHS only gives ninety days notice to the health plan. The result is that the health plan has only thirty days to provide the notice to its enrollees. Medica suggested reducing the notice period to thirty days. The Department responded that, under Minn. Stat. § 62D.12, subd. 2a, health plans must give ninety days notice to enrollees entitled to replacement coverage. Department Comment, at 17-18. All enrollees would be entitled to that coverage where the Department contract is being terminated. Since the MinnesotaCare rule is applying to enrollees in plans not covered by Minn. Stat. § 62D.12, the rule is both needed and reasonable to set the standard for health plans not covered by a more stringent statutory provision. Where a more stringent standard is in an applicable statute, however, the statutory standard applies. Subpart 14 is needed and reasonable as proposed.

Definition of Primary Care Provider

52. Scott L. Mayer, General Counsel of the Minnesota Chiropractic Association, and David N. Kunz, Executive Director of the Minnesota Optometric Association, urged DHS adopt a definition of “primary care provider” that includes chiropractors and optometrists, respectively. Suzanne M. Veenhuis of the MMA suggested that any such definition include “any physician licensed pursuant to chapter 147 who has appropriate primary care training and competence.” The Department has declined to adopt any definition of primary care provider, preferring to leave staffing decisions to health plans. Any problems with a particular choice can be dealt with through the plan’s appeal process. This issue has arisen repeatedly in rulemaking proceedings and both DHS and the Department of Health have chosen to leave primary care provider decisions within the responsibility of the health plans. For some plans, the level of enrollee interest may make providing an allied service provider a primary care provider. For other plans, the level of interest may render the selection of an allied service provider as a primary care provider to be uneconomical. Leaving the choice to each health plan is within the discretion of the Department and does not render the proposed rules defective.

Incorporating PMAP Restrictions on Subcontractors

53. Legal Aid urged that the limitations on subcontractors in the PMAP rules be incorporated into the MinnesotaCare rule. These limitations require the termination of subcontractors from a health plan for reasons such as failing to comply with Department of Health licensure standards, termination from the MA program, or providing poor quality services. DHS declined to add those standards, maintaining that the existing quality assurance standards and licensure standards are adequate to protect the interests of enrollees. This choice has been shown to be needed and reasonable.

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

CONCLUSIONS

1. The Minnesota Department of Human Services (“the Department”) gave proper notice of this rulemaking hearing.
2. The Department has substantially fulfilled the procedural requirements of Minn. Stat. §§ 14.14, subds. 1, 1a and 14.14, subd. 2 (1992), and all other procedural requirements of law or rule so as to allow it to adopt the proposed rules.
3. The Department has demonstrated 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) (1992), except as noted at Finding 22.

4. The Department 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) (1992), except as noted at Findings 22 and 23.

5. The additions or amendments to the proposed rules suggested by the Department 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 (1992), and Minn. Rules pts. 1400.1000, subp. I and 1400.1100 (1991).

6. The Administrative Law Judge has suggested action to correct the defects cited in Conclusions 3 and 4, as noted at Findings 22 and 23.

7. Due to Conclusions 3, 4 and 6, this Report has been referred to the Chief Administrative Law Judge for his approval pursuant to Minn. Stat. § 14.15, subd. 3 (1992).

8. Any Findings which might properly be termed Conclusions are hereby adopted as such.

9. A Finding or Conclusion of need and reasonableness in regard to any particular rule subsection does not preclude and should not discourage the Department from further modification of the proposed 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 be adopted except where otherwise noted above.

Dated this _____ day of June, 1995.

ALLEN E. GILES
Administrative Law Judge

Reported: Tape Recorded; No Transcript Prepared, Two Tapes