..... moves to amend H.F. No. 2038, the first engrossment, as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2014, section 256B.69, subdivision 5a, is amended to read:

Subd. 5a. **Managed care contracts.** (a) Managed care contracts under this section and section 256L.12 shall be entered into or renewed on a calendar year basis. The commissioner may issue separate contracts with requirements specific to services to medical assistance recipients age 65 and older.

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

(c) The commissioner shall withhold five percent of managed care plan payments under this section and county-based purchasing plan payments under section 256B.692 for the prepaid medical assistance program pending completion of performance targets. Each performance target must be quantifiable, objective, measurable, and reasonably attainable, except in the case of a performance target based on a federal or state law or rule. Criteria for assessment of each performance target must be outlined in writing prior to the contract effective date. Clinical or utilization performance targets and their related criteria must consider evidence-based research and reasonable interventions when available or applicable to the populations served, and must be developed with input from external clinical experts and stakeholders, including managed care plans, county-based purchasing plans, and providers. The managed care or county-based purchasing plan must demonstrate, to the commissioner's satisfaction, that the data submitted regarding attainment of the performance target is accurate. The commissioner shall periodically change the administrative measures used as performance targets in order to improve plan

performance across a broader range of administrative services. The performance targets must include measurement of plan efforts to contain spending on health care services and administrative activities. The commissioner may adopt plan-specific performance targets that take into account factors affecting only one plan, including characteristics of the plan's enrollee population. The withheld funds must be returned no sooner than July of the following year if performance targets in the contract are achieved. The commissioner may exclude special demonstration projects under subdivision 23.

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

(e) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the health plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. For 2012, the reduction shall be based on the health plan's utilization in 2009. To earn the return of the withhold each subsequent year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of no less than ten percent of the plan's emergency department utilization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23 and 28, compared to the previous measurement year until the final performance target is reached. When measuring performance, the commissioner must consider the difference in health risk in a managed care or county-based purchasing plan's membership in the baseline year compared to the measurement year, and work with the managed care or county-based purchasing plan to account for differences that they agree are significant.

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

The withhold described in this paragraph shall continue for each consecutive contract period until the plan's emergency room utilization rate for state health care program enrollees is reduced by 25 percent of the plan's emergency room utilization rate for medical

assistance and MinnesotaCare enrollees for calendar year 2009. Hospitals shall cooperate with the health plans in meeting this performance target and shall accept payment withholds that may be returned to the hospitals if the performance target is achieved.

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

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

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

(g) Effective for services rendered on or after January 1, 2012, the commissioner shall include as part of the performance targets described in paragraph (c) a reduction in the plan's hospitalization admission rates for subsequent hospitalizations within 30 days of a previous hospitalization of a patient regardless of the reason, for medical assistance and MinnesotaCare enrollees, as determined by the commissioner. To earn the return of the withhold each year, the managed care plan or county-based purchasing plan must achieve a qualifying reduction of the subsequent hospitalization rate for medical assistance and MinnesotaCare enrollees, excluding enrollees in programs described in subdivisions 23

and 28, of no less than five percent compared to the previous calendar year until the final performance target is reached.

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

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

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

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

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

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

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

(m) Managed care plans and county-based purchasing plans shall maintain current and fully executed agreements for all subcontractors, including bargaining groups, for administrative services that are expensed to the state's public programs. Subcontractor agreements of over $200,000 in annual payments must be in the form of a written instrument or electronic document containing the elements of offer, acceptance, and consideration, and must clearly indicate how they relate to state public programs. Upon request, the commissioner shall have access to all subcontractor documentation under this paragraph. Nothing in this paragraph shall allow release of information that is nonpublic data pursuant to section 13.02.

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

Subd. 5i. **Administrative expenses.** (a) ~~Managed care plan and county-based purchasing plan~~ Administrative costs ~~for a prepaid health plan provided~~ paid to managed care plans and county-based purchasing plans under this section ~~or~~, section 256B.692, and section 256L.12 must not exceed ~~by more than five~~ 6.6 percent ~~that prepaid health plan's or county-based purchasing plan's actual calculated administrative spending for the previous calendar year as a percentage of total revenue~~ of total payments expected to be made to all managed care plans and county-based purchasing plans in aggregate across all state public programs at the beginning of each calendar year. ~~The penalty for exceeding this limit must be the amount of administrative spending in excess of 105 percent of the actual calculated amount. The commissioner may waive this penalty if the excess administrative spending is the result of unexpected shifts in enrollment or member needs or new program requirements.~~ The commissioner may reduce or eliminate administrative requirements to meet the administrative cost limit. For purposes of this paragraph, administrative costs do not include any state or federal taxes, surcharges, or assessments.

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

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

(2) ~~any portion of an individual's compensation in excess of $200,000 paid by the managed care plan or county-based purchasing plan~~ compensation of individuals within the organization in excess of $200,000 such that the allocation of compensation for an individual across all state public programs in total cannot exceed $200,000;

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

(4) any indirect marketing or advertising expenses of the managed care plan or county-based purchasing plan. for marketing that does not specifically target state public programs beneficiaries and that has not been approved by the commissioner;

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

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

(7) alcoholic beverages and related costs;

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

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

For the purposes of this subdivision, compensation includes salaries, bonuses and incentives, other reportable compensation on an IRS 990 form, retirement and other deferred compensation, and nontaxable benefits. Contributions include payments for or to any organization or entity selected by the health maintenance organization that is operated for charitable, educational, political, religious, or scientific purposes and not related to the provision of medical and administrative services covered under the state public programs, except to the extent that they improve access to or the quality of covered services for state public programs beneficiaries, or improve the health status of state public programs beneficiaries.

(c) Administrative expenses must be reported using the formats designated by the commissioner as part of the rate-setting process and must include, at a minimum, the following categories:

(1) employee benefit expenses;

(2) sales expenses;

(3) general business and office expenses;

(4) taxes and assessments;

(5) consulting and professional fees; and

(6) outsourced services.

Definitions of items to be included in each category shall be provided by the commissioner with quarterly financial filing requirements and shall be aligned with definitions used by the Departments of Commerce and Health in financial reporting for commercial carriers. Where reasonably possible, expenses for an administrative item shall be directly allocated so as to assign costs for an item to an individual state public program when the cost can be specifically identified with and benefits the individual state public program. For administrative services expensed to the state's public programs, managed care plans

and county-based purchasing plans must clearly identify and separately record expense items listed under paragraph (b) in their accounting systems in a manner that allows for independent verification of unallowable expenses for purposes of determining payment rates for state public programs.

(d) The administrative expenses requirement of this subdivision also apply to demonstration providers under section 256B.0755.

Sec. 3. Minnesota Statutes 2014, section 256B.69, subdivision 9c, is amended to read:

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

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

(1) an income statement by program;

(2) financial statement footnotes;

(3) quarterly profitability by program and population group;

(4) a medical liability summary by program and population group;

(5) received but unpaid claims report by program;

(6) services versus payment lags by program for hospital services, outpatient services, physician services, other medical services, and pharmaceutical benefits;

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

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

(9) subcapitation expenses by population group;

(10) third-party payments by program;

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

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

(13) medical loss ratios by program;

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

(15) revenues by program, including investment income;

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

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

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

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

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

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

(18) contribution to reserve, by program.

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

The quarterly reports shall be submitted to the commissioner no later than 60 days after the end of the previous quarter, except the fourth-quarter report, which shall be submitted by April 1 of each year. The fourth-quarter report shall include audited financial statements, parent company audited financial statements, an income statement reconciliation report,

and any other documentation necessary to reconcile the detailed reports to the audited financial statements.

(d) Managed care plans and county-based purchasing plans shall certify to the commissioner, for the purpose of managed care financial reporting for state public health care programs under this subdivision, that costs related to state public health care programs include only services covered under the state plan and waivers, and related allowable administrative expenses. Managed care plans and county-based purchasing plans shall certify and report to the commissioner the dollar value of any unallowable and nonstate plan services, including both medical and administrative expenditures, for the purposes of managed care financial reporting under this subdivision.

(e) The financial reporting requirements of this subdivision also apply to demonstration providers under section 256B.0755.

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

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

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

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

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

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

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

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

(e) The commissioner may conduct ad hoc audits of the state public programs administrative and medical expenses of managed care organizations and county-based

purchasing plans. This includes: financial and encounter data reported to the commissioner under subdivision 9c, including payments to providers and subcontractors; supporting documentation for expenditures; categorization of administrative and medical expenses; and allocation methods used to attribute administrative expenses to state public programs. These audits also must monitor compliance with data and financial certifications provided to the commissioner for the purposes of managed care capitation payment rate-setting. The managed care plans and county-based purchasing plans shall fully cooperate with the audits in this subdivision.

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

(g) The audit requirements of this subdivision also apply to demonstration providers under section 256B.0755.

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

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

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

Sec. 6. Laws 2008, chapter 363, article 18, section 3, subdivision 5, is amended to read:

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

(a) **MinnesotaCare Grants**

Health Care Access	-0-	(770,000)

Incentive Program and Outreach Grants.

Of the appropriation for the Minnesota health

care outreach program in Laws 2007, chapter 147, article 19, section 3, subdivision 7, paragraph (b):

(1) $400,000 in fiscal year 2009 from the general fund and $200,000 in fiscal year 2009 from the health care access fund are for the incentive program under Minnesota Statutes, section 256.962, subdivision 5. For the biennium beginning July 1, 2009, base level funding for this activity shall be $360,000 from the general fund and $160,000 from the health care access fund; and

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

(b) **MA Basic Health Care Grants - Families and Children** -0- (17,280,000)

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

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

the commissioner for technology-related expenses.

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

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

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

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

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

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

Minnesota Disability Health Options Rate Setting Methodology. The commissioner shall develop and implement a methodology for risk adjusting payments for community alternatives for disabled individuals (CADI) and traumatic brain injury (TBI) home and community-based waiver services delivered under the Minnesota disability health options program (MnDHO) effective January 1, 2009. The commissioner shall take into account the weighting system used to determine county waiver allocations in developing the new payment methodology. Growth in the number of enrollees receiving CADI or TBI waiver payments through MnDHO is limited to an increase of 200 enrollees in each calendar year from January 2009 through December 2011. If those limits are reached, additional members may be enrolled in MnDHO for basic care services only as defined under Minnesota Statutes, section 256B.69, subdivision 28, and the commissioner may establish a waiting list for future access of MnDHO members to those waiver services.

MA Basic Elderly and Disabled Adjustments. For the fiscal year ending June 30, 2009, the commissioner may adjust the

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

(d) **General Assistance Medical Care Grants**	-0-	(6,971,000)
(e) **Other Health Care Grants**	-0-	(17,000)

MinnesotaCare Outreach Grants Special Revenue Account. The balance in the MinnesotaCare outreach grants special revenue account on July 1, 2009, estimated to be $900,000, must be transferred to the general fund.

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

Sec. 7. **ADVISORY GROUP ON ADMINISTRATIVE EXPENSES.**

The commissioner of health shall reconvene the Advisory Group on Administrative Expenses, established under Laws 2010, First Special Session chapter 1, article 20, section 3, to develop detailed standards and procedures for examining the reasonableness of administrative expenses by individual state public programs. The advisory group shall develop consistent guidelines, definitions, and reporting requirements, including a common standardized public reporting template for health maintenance organizations and county-based purchasers that participate in state public programs. The advisory group shall take into consideration relevant reporting standards of the National Association of Insurance Commissioners and the Centers for Medicare and Medicaid Services. The membership of the advisory group shall be as described in Laws 2010, First Special Session chapter 1, article 20, section 3. The advisory group shall expire upon completion of the duties established under this section."

Amend the title accordingly