HOUSE RESEARCH
Bill Summary

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Overview

This bill requires an annual independent financial audit of managed care and county-based purchasing plans that provide care for enrollees in state public health care programs. The bill requires DHS to annually assess plans for the cost of agency implementation of the financial audit requirements. The bill also eliminates or modifies certain plan reporting requirements based upon recommendations of the 2012 report to the Legislature - "Regulatory Simplification and Reduction of Provider Reporting and Data Submission Requirements" by Management Analysis and Development, Minnesota Management and Budget.

1 **Standards for claim denial.** Amends § 72A.201, subd. 8. Eliminates certain insurer reporting requirements related to the evaluation standards and criteria used by chemical dependency reviewers to deny insurance claims for chemical dependency services. Provides an immediate effective date.

2 **Managed care financial reporting.** Amends § 256B.69, subd. 9c. A new paragraph (d) requires that the legislative auditor contract for the audit required in this paragraph. Directs the legislative auditor to require, in requests for bids and the resulting contracts for Medical Assistance coverage, that the managed care and county-based purchasing plans agree to submit to and fully cooperate with an annual independent third-party financial audit. Requires audit firms to be independent in accordance with government auditing standards issued by the U.S. Government Accountability Office (GAO). Prohibits an audit firm performing the independent audit from providing services to a plan at the same time, or in the prior three years.

(e) Requires audits to be conducted in accordance with generally accepted government auditing standards issued by the GAO.

(f) Requires that the health plans provide biweekly encounter and claims data at a detailed level to the commissioner and participate in a quality assurance program. Requires the commissioner to contract with an independent third-party auditing firm to evaluate the quality assurance protocols and implementation of the protocols.

(g) Requires that contracts with the plans permit the commissioner unlimited access to the data

needed to perform the audit, including power to enforce that requirement in court if necessary.

(h) Prohibits an actuary or actuarial firm that provides actuarial services to the commissioner to provide services of any kind to the managed care and county-based purchasing plans during the term of the actuarial firm's work for the commissioner.

(i) Requires the actuary or actuarial firm referenced in paragraph (h) to certify and attest to the rates paid to the managed care and county-based purchasing plans, and those rates must be auditable.

(j) Requires that the audit must include a determination regarding compliance with the federal Medicaid rate certification process.

(k) Requires that the legislative auditor's auditing contract be designed and administered to qualify for a federal subsidy if available.

(l) Requires that the legislative auditor 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 finance committees of the legislature.

(m) Requires the commissioner to annually assess plans for reasonable agency costs related to implementing the independent audits. Requires the amount assessed each plan to be proportional to the plan's share of state health care program enrollment.

Effective date: Makes the bill effective immediately and apply to managed care contracts and the contracting process for contracts that are effective January 1, 2013, and thereafter.

3 **Savings from report elimination.** Amends § 256B.659, by adding subd. 9d. Requires managed care and county-based purchasing plans to use all savings resulting from elimination or modification of reporting requirements in other sections of the bill to pay the assessment required by subdivision 9c, paragraph (m). Provides an immediate effective date.

4 **Reporting requirements.**

Subd. 1. Evidence-based childbirth program. Allows the commissioner of human services to discontinue the evidence-based childbirth program, and requires the commissioner to discontinue affiliated reporting requirements once certain goals for the program have been achieved.

Subd. 2. Provider networks. Requires the commissioners of health, commerce, and human services to merge certain HMO and county-based purchasing plan reporting requirements related to network adequacy and provider lists.

Provides an immediate effective date.

5 **Repealer.**

Subd. 1. Summary of complaints and grievances. Repeals Minnesota Rules, part 4685.2000 (report providing an annual summary of HMO and county-based purchasing plan complaints and grievances), the day following final enactment.

Subd. 2. Medical necessity denials and appeals. Repeals § 62M.09, subd. 9 (report on number and rate of medical necessity denials and appeals by utilization review organizations), the day following final enactment.

Subd. 3. Salary reports. Repeals § 62Q.64 (report on high-five salaries for HMOs and county-based purchasing plans), the day following final enactment.