STATE OF MINNESOTA
IN COURT OF APPEALS
A22-1643

South Country Health Alliance, et al.,
Appellants,

vs.

Minnesota Department of Human Services, et al.,
Respondents,

Medica Health Plans,
Respondent,

HMO Minnesota,
Respondent,

HealthPartners, Inc.,
Respondent,

UCare Minnesota,
Respondent,

UnitedHealthcare of Illinois,
Respondent.

Filed August 14, 2023
Affirmed in part, reversed in part, and remanded
Connolly, Judge

Ramsey County District Court
File No. 62-CV-22-907

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Considered and decided by Reilly, Presiding Judge; Connolly, Judge; and Slieter, Judge.

SYLLABUS

I. The Minnesota Department of Human Services may not avoid complying with the unambiguous language of Minn. Stat. § 256B.69, subd. 3a(c) (2022), which concerns county-based purchasing in relation to the state's Medicaid program, by asserting that it has not received federal approval under Minn. Stat. § 256B.692, subd. 9 (2022), if the federal government has not definitively prohibited county-based purchasing, and the department has implemented county-based purchasing in the past.

II. There is no irreconcilable conflict between Minn. Stat. § 256B.694 (2022) and Minn. Stat. § 256B.69, subd. 3a(c), they can be read in harmony, and section 256B.694 does not give the department discretion as to whether to comply with the county-based purchasing requirements of section 256B.69, subdivision 3a(c).

III. Under the unambiguous language of Minn. Stat. § 256B.69, subd. 3a(d) (2022), an entity created by a joint-powers agreement, executed by its member counties to

engage in county-based purchasing, is entitled to mediation as set forth in subdivision 3a(d).

OPINION

CONNOLLY, Judge

Appellants, entities created to engage in county-based purchasing for Minnesota's Medicaid program, challenge the summary-judgment dismissal of their claims for declaratory and injunctive relief against respondents Minnesota Department of Human Services (DHS) and Commissioner of Human Services Jodi Harpstead. Appellants claim that the district court erred because (1) under Minn. Stat. § 256B.69, subd. 3a(c), DHS has no authority to implement a prepaid medical assistance program in counties that have elected county-based purchasing; (2) under Minn. Stat. § 256B.692 (2022), DHS must pay a county-based purchasing entity that meets all statutory and regulatory requirements; and (3) under Minn. Stat. § 256B.69, subd. 3a(d), appellants are entitled to mediation. We affirm in part, reverse in part, and remand for consideration of appropriate injunctive relief.

FACTS

Medicaid is a cooperative federal-state program that provides medical assistance for certain persons "whose income and resources are insufficient to meet the costs of necessary medical services." 42 U.S.C. § 1396-1 (2018); *Alexander v. Choate*, 469 U.S. 287, 289 n.1 (1985); *In re Schmalz*, 945 N.W.2d 46, 50 (Minn. 2020). A state's participation in Medicaid is voluntary. *Choate*, 469 U.S. at 289 n.1; *Schmalz*, 945 N.W.2d at 50. Participating states share the costs with the federal government to provide health care to Medicaid enrollees and must comply with the requirements of federal statutes and

regulations to receive Medicaid funding. *Choate*, 469 U.S. at 289 n.1; *Schmalz*, 945 N.W.2d at 50.

Minnesota began participating in Medicaid in 1966. Minnesota's Medicaid program is known as Medical Assistance (MA). *Schmalz*, 945 N.W.2d at 50. DHS is responsible for administering the MA program. *See* Minn. Stat. § 256.01, subd. 2(a) (2022) (stating that the DHS commissioner shall "[a]dminister and supervise all forms of public assistance provided for by state law").

Minnesota initially used a fee-for-service model to distribute Medicaid funds, meaning health-care providers would bill the state directly for services rendered to enrollees. Then in the 1980s, Minnesota began using a managed-care model in a handful of counties; the managed-care model is referred to as the prepaid medical assistance program or PMAP. *See* 1983 Minn. Laws ch. 312, art. 5, § 27, at 1833-36; *See also* Minn. Stat. § 256B.69 (2022).

Under the managed-care model, Medicaid beneficiaries enroll in a managed-care organization or MCO, which is under contract with the state. The MCO serves enrollees on a prepaid basis, meaning the state pays the MCO a fixed, per-enrollee rate, and the MCO pays providers for costs of care.[1] In 1990, PMAP was extended statewide. *See* 1990 Minn. Laws ch. 568, art. 3, § 83, at 1906. Today, most Medicaid beneficiaries in Minnesota receive health-care coverage through an MCO.

[1] The state's contracts with MCOs are full risk-bearing contracts, which means that the MCOs remain responsible for paying an enrollee's provider for the enrollee's cost of care, even if the cost exceeds the rate the MCOs received from the state. *See* 42 U.S.C. § 1396u-2 (2018) (permitting states to utilize MCOs).

In 1997, Minnesota developed an alternative to PMAP known as county-based purchasing or CBP. *See* 1997 Minn. Laws ch. 203, art 4, § 56, at 1713-16 (codified at Minn. Stat. § 256B.692 (Supp. 1997)). Under the CBP model, county boards or groups of county boards may elect to purchase or provide health-care services on behalf of persons eligible for MA "who would otherwise be required to or may elect to participate in the prepaid medical assistance program." Minn. Stat. § 256B.692, subd. 1.

Appellants South Country Health Alliance (South Country), PrimeWest Rural Minnesota Health Care Access Initiative (PrimeWest), and Itasca Medical Care (IMCare) are CBP entities established by 33 rural Minnesota counties. Under Minn. Stat. § 471.59, subd. 1(a) (2022), governmental units may contract to exercise a common power, and South Country and PrimeWest were established by contract as joint-powers entities for eight and 24 member counties, respectively. IMCare was established and is operated by Itasca County as a division of its Health and Human Services Department.

DHS initially contracted with CBP entities that met program standards. In 2011, DHS began utilizing a competitive bidding procurement process for MCO contracts. DHS began issuing requests for proposals or RFPs prior to contracting with MCOs.

In 2015, competitive bidding was used to select MA plans in all Minnesota counties. That year, DHS informed South Country that, as part of its procurement process, it intended to negotiate contracts to provide prepaid medical assistance services to enrollees in South Country's CBP counties. Section 256B.69, subdivision 3a(c), states, in part: "For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely

preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county." Based on that statute, South Country's member counties challenged in mediation DHS's decision to implement PMAP in CBP counties, and a DHS mediation panel concluded that section 256B.69, subdivision 3a(c), precluded DHS "from selecting any prospective vendor other than the CBP." The then-commissioner reversed her initial decision, in part, granting South Country a contract, but requiring it to operate alongside a PMAP plan. The commissioner indicated that her decision was intended to give the legislature "the opportunity to address this issue in a more straightforward manner." The legislature did not act.

In 2019, DHS conducted a new managed-care procurement for contracts beginning in 2020. This time, South Country was not offered a contract for any of its member counties. IMCare was not offered a contract for Itasca County, except as one of several plans for the Minnesota Senior Health Options/Minnesota Senior CarePlus (Seniors) programs.[2] PrimeWest, which had recently added 11 member counties to its original 13, was not offered a contract as the single plan for the Seniors programs in any of its member counties and was offered a contract to be the single plan for MA only in its original 13 counties.

[2] Minnesota Senior Health Options (MSHO) is an optional program for people ages 65 and older who are eligible for MA and enrolled in Medicare Parts A and B that offers fully integrated Medicare and Medicaid coverage under a single MCO. *See* Minn. Stat. § 256B.69, subd. 23. Minnesota Senior CarePlus is a prepaid MA program for people ages 65 years and older who do not choose MSHO. *See id.*

South Country, along with member counties for all three CBP entities, requested mediation to challenge these procurement decisions. When DHS refused, South Country challenged the decision in district court. The district court temporarily enjoined DHS from entering into new managed-care contracts in South Country's member counties and granted South Country's request to compel mediation. Rather than proceed with mediation, DHS canceled the procurement and renewed the existing contracts. Once again, the then-commissioner indicated that this result would allow the legislature to "clarify aspects of the contracting process," but again the legislature did not act.

In October 2021, DHS began issuing the RFPs at the heart of this litigation. DHS issued RFPs for both the Seniors and Special Needs BasicCare (SNBC) programs.[3] Proposals were due February 18, 2022. In January 2022, DHS issued an RFP for the Families and Children Medical Assistance (Families and Children) program,[4] with proposals due April 1, 2022. The Seniors and SNBC RFPs indicated that DHS intended to select multiple plans for each county and that DHS had predetermined certain additional criteria that a plan would have to meet before DHS would consider a single-plan contract. The Families and Children RFP stated that a minimum of two MCOs would "be selected in each of the 80 counties" covered in the RFP. The RFP also stated that a responding CBP

[3] SNBC is an optional managed care program for MA enrollees with disabilities ages 18-64 who may or may not also be eligible for Medicare. *See* Minn. Stat. § 256B.69, subd. 28. Integrated SNBC is an optional program for individuals who elect managed care, are eligible for both SNBC and Medicare, and wish to enroll in a fully integrated Medicare and Medicaid plan under a single MCO. *See id.*

[4] Families and Children, or F&C, is Minnesota's general MA program, which provides health care coverage to individuals and families below established asset and income eligibility guidelines.

entity would be selected for a contract only "subject to the [c]ommissioner's authority" and after meeting certain requirements. None of the three RFPs indicated that DHS would defer to a county's choice of a CBP plan. Regardless of the mandates of section 256B.692, DHS asserted the authority in all three RFPs to "[r]eject any and all" proposals, to "accept or reject any recommendation of the evaluation team," and to conduct an "audit of the reasonableness" of a proposal.

On February 8, 2022, appellants sent a letter asking the DHS commissioner to convene a mediation panel under Minn. Stat. § 256B.69, subd. 3a(d).[5] DHS refused to allow appellants to mediate, taking the position that only appellants' member counties were entitled to mediate.

On February 17, 2022, appellants filed a complaint with the district court, alleging that DHS had "force[d] PMAP into counties that ha[d] selected CBPs." Count I of the complaint sought a declaration, pursuant to Minn. Stat. § 555.01 (2022), that DHS's procurement process violates appellants' rights under sections 256B.692 and 256B.69, subdivision 3a(c). Count II sought a declaration that appellants are entitled to participate in mediation under section 256B.69, subdivision 3a(d). Count III sought injunctive relief and alleged that DHS's procurement process violated sections 256B.692 and 256B.69. Count IV also sought injunctive relief; specifically, appellants sought an order or injunction

[5] That subdivision states that if "a county board or a single entity representing a group of county boards and the commissioner cannot reach agreement" on "the selection of participating health plans in that county," or "contract requirements," or "implementation and enforcement of county requirements," then "the commissioner shall resolve all disputes after taking into account the recommendations of a three-person mediation panel." Minn. Stat. § 256B.69, subd. 3a(d).

requiring DHS to seek federal waivers and approval for CBP if the district court concluded that any federal statute or regulation created an impediment to compliance with sections 256B.692 or 256B.69.[6]

In March 2022, the district court entered a stipulated order joining five private MCOs as defendants: respondents Medica Health Plans (Medica), HMO Minnesota d/b/a Blue Plus (Blue Plus), HealthPartners, Inc., UCare Minnesota, and UnitedHealthCare of Illinois. The parties filed cross-motions for summary judgment. The district court denied appellants' motion for summary judgment and granted summary judgment for respondents.

In ruling on the parties' summary-judgment motions, the district court examined section 256B.69, subdivision 3a(c), and concluded that appellants presented a "fair reading" of the statute "that once CBP has been established[,] . . . the commissioner loses all discretion to seek proposals for PMAP in that county until CBP is no longer operational." But the district court disagreed with that interpretation, concluding that the statute "may, at one time, have constituted a situational legislative preference for continuing CBP in limited geographic areas,"[7] but that the statute "in current context" was

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[6] Respondent Medica argues that appellants are, in effect, pursuing "an invalid mandamus action" because appellants are seeking "an order forcing DHS to take certain actions," and "mandamus cannot be used to compel an action over which the agency has discretion." A "writ of mandamus may be issued to any inferior tribunal, corporation, board, or person to compel the performance of an act which the law specially enjoins as a duty resulting from an office, trust, or station." Minn. Stat. § 586.01 (2022). Mandamus is inappropriate "where there is a plain, speedy, and adequate remedy in the ordinary course of law." Minn. Stat. § 586.02 (2022). Appellants' complaint makes no mention of mandamus, and given Medica's failure to cite any persuasive authority, we decline to recharacterize appellants' claims as an invalid mandamus action.

[7] While the district court used the term "situational legislative preference," we believe the better descriptor is a duly enacted law.

not consistent with appellants' interpretation. The district court concluded that Minn. Stat. § 256B.694 granted the commissioner discretion on whether to contract with, and pay, a CBP entity. The district court also concluded that CBP could not be implemented without further federal waivers. Finally, the district court determined that appellants were not entitled to mediate under section 256B.69, subdivision 3a(d).

This appeal followed.

ISSUES

I. Under section 256B.69, subdivision 3a(c), is DHS prohibited from implementing PMAP in a county that elects CBP?

II. Under section 256B.692, subdivisions 1 and 4, is DHS required to pay a CBP entity that meets all statutory and regulatory requirements?

III. Are appellants entitled to mediation under section 256B.69, subdivision 3a(d)?

ANALYSIS

On review of summary judgment, we analyze whether there are genuine disputes of material fact and whether the district court erred in its application of law. *Montemayor v. Sebright Prods., Inc.*, 898 N.W.2d 623, 628 (Minn. 2017). When considering the record on summary judgment, we "view the evidence in the light most favorable to the party against whom summary judgment was granted." *STAR Ctrs., Inc. v. Faegre & Benson, L.L.P.*, 644 N.W.2d 72, 76-77 (Minn. 2002). Summary judgment is proper if the moving party shows that "there is no genuine issue as to any material fact and the movant is entitled to judgment as a matter of law" based on the record, which may include depositions, documents, affidavits, admissions, and interrogatory answers. Minn. R. Civ. P. 56.01, 56.03(a). A genuine issue of material fact exists "when reasonable persons might draw

different conclusions from the evidence presented." *DLH, Inc. v. Russ*, 566 N.W.2d 60, 69 (Minn. 1997).

I.

Appellants argue that the district court erred in concluding that DHS may implement PMAP in a county that elects CBP because the unambiguous text of section 256B.69, subdivision 3a(c), states that DHS "shall not implement" PMAP in a CBP county.

Questions of statutory interpretation are reviewed de novo. *Thompson v. Schrimsher*, 906 N.W.2d 495, 498 (Minn. 2018). "The first step in statutory interpretation is to determine whether the statute's language, on its face, is ambiguous." *Larson v. State*, 790 N.W.2d 700, 703 (Minn. 2010) (quotation omitted). "A statute is ambiguous only when the statutory language is subject to more than one reasonable interpretation." *State v. Fleck*, 810 N.W.2d 303, 307 (Minn. 2012). If a statute is unambiguous, we "apply the statute's plain meaning." *Larson*, 790 N.W.2d at 703. If a statute is ambiguous, then we may resort to the canons of statutory construction to determine its meaning. *State v. Hayes*, 826 N.W.2d 799, 804 (Minn. 2013). To ascertain the meaning of an ambiguous statute, we may consider various factors relevant to legislative intent. Minn. Stat. § 645.16 (2022).

Section 256B.69, subdivision 3a(c), states:

> For counties in which a prepaid medical assistance program has not been established, the commissioner shall not implement that program if a county board submits an acceptable and timely preliminary and final proposal under section 256B.692, until county-based purchasing is no longer operational in that county. For counties in which a prepaid medical assistance program is in existence on or after September 1, 1997, the commissioner must terminate contracts with health plans according to section 256B.692, subdivision

> 5, if the county board submits and the commissioner accepts a preliminary and final proposal according to that subdivision. The commissioner is not required to terminate contracts that begin on or after September 1, 1997, according to section 256B.692 until two years have elapsed from the date of initial enrollment.

The statute unambiguously declares that DHS may not "implement" PMAP in a CBP county if the county "submits an acceptable and timely preliminary and final proposal under section 256B.692." Minn. Stat. § 256B.69, subd. 3a(c). Further, the statute plainly indicates that, if PMAP is in the county on or after September 1997, and the county wants to switch to CBP, DHS must terminate the PMAP contracts "if the county board submits and the commissioner accepts a preliminary and final proposal" under Minn. Stat. § 256B.692, subd. 5.[8] *Id.* But DHS "is not required to terminate [PMAP] contracts that begin" after September 1997 "until two years have elapsed from the date of initial enrollment" in CBP. *Id.*

Appellants argue that DHS violated the statute because DHS announced that it would contract with multiple plans in nearly all of appellants' member counties. DHS concedes that its RFPs for the procurement of contracts to begin January 1, 2023, generally provided that, if possible, at least two MCOs would be selected for each county subject to the procurement. DHS further concedes that CBPs were not guaranteed "single-plan status in their counties." Rather than direct its arguments at the plain language of Minn. Stat. § 256B.69, subd. 3a(c), DHS offers two primary arguments for why Minn. Stat. § 256B.69, subd. 3a(c), is not controlling.

[8] Section 256B.692, subdivision 5, covers CBP proposals.

First, DHS argues that under Minn. Stat. § 256B.692, subd. 9, CBP must comply with federal statutes and regulations, and because the PMAP implementation restrictions in Minn. Stat. § 256B.69, subd. 3a(c), are inconsistent with federal requirements, DHS need not adhere to those restrictions.

Under section 256B.692, subdivision 9, the DHS commissioner "shall request any federal waivers and federal approval required to implement this section," and "[c]ounty-based purchasing shall not be implemented without obtaining all federal approval required to maintain federal matching funds in the medical assistance program."

DHS points to three federal requirements that it argues conflict with the PMAP implementation restrictions in Minn. Stat. § 256B.69, subd. 3a(c): (1) a competitive-procurement requirement, (2) a single-state-agency requirement, and (3) a choice-of-health-plan requirement.

Before addressing DHS's federal-waiver arguments, we first discuss some of DHS's past efforts to comply with the waiver requirement in subdivision 9. In 1999, in attempting to implement CBP, DHS formally requested from the federal Health Care Financing Administration (HCFA) a waiver of certain federal requirements. DHS acknowledged in the request that under the CBP model the state would "delegate designated purchasing functions to county or multi-county boards on a sole source, non-competitive basis." DHS sought waivers for numerous federal regulations and statutes, including regulations and statutes requiring that states "allow enrollees to choose a managed care entity from among at least two such entities," and requiring that "procurement transactions conducted by recipients of [f]ederal funds allow for competition to the maximum extent practical."

In April 1999, HCFA responded to DHS's waiver request and noted "four major issues" that could "significantly impact the ability to reach resolution" on the waiver request. The first was "competitive procurement," specifically, a federal regulation, 45 C.F.R. § 74.43 (2004), that required all procurement transactions to be conducted "to the maximum extent practical" to allow for open and free competition. HCFA requested "a detailed justification" as to why a sole source contracting arrangement was necessary, "including a discussion of why competitive procurement is not practical or preferable." The other three issues identified by HCFA were (1) "Choice of Medicaid Managed Care Plans" based on an HCFA policy requiring a choice of at least two MCOs, (2) "Administrative Efficiency" of the CBP model, and (3) lack of "operational details." HCFA requested an "explanation" for why restriction of MCO choices was necessary, and "justification" for the approval of a model lacking operational details.

Based on the record before us, neither HCFA nor the Centers for Medicare and Medicaid Services (CMS), the federal entity responsible for implementing the Medicaid program, ever explicitly granted or denied DHS's general waiver request for the CBP model. As HCFA noted in its April 1999 reply: "The details of each administrative structure and delivery system are dependent upon the model selected by each county, or group of counties," and "HCFA would need to approve each model as presented."

However, in December 1999, a project officer for HCFA responded to a DHS request to implement CBP in five counties through a joint-powers agreement known as Essential Health Plan (EHP). HCFA's response stated in part:

> The regulations at 45 C.F.R. 74.43 provide that all procurement transactions shall be conducted in a manner to provide, "to the maximum extent practical," open and free competition. HCFA's policy regarding sole source contracting has been that states must enter into open procurement arrangements whenever practical. While we would like to provide flexibility to rural areas, such as counties composing EHP, and the arguments presented regarding the ability of the EHP to integrate care and improve access to providers are compelling, there does not appear to be sufficient justification as to why an open procurement is not practical. Therefore, we are asking you to conduct an open procurement for the EHP catchment area, and eventually for all the [CBP] areas for which you subsequently submit proposals.

Returning to DHS's federal-waiver arguments, and specifically its competitive-procurement argument, we note that DHS asserts that it has "never received the federal approval or waivers necessary to award contracts to CBPs noncompetitively." DHS argues that although under certain circumstances it can contract on a single-plan basis with CBPs, the federal government has not waived requirements that Medicaid contracts be competitively procured. DHS acknowledges that HCFA's competitive-procurement response was predicated on a federal regulation (45 C.F.R. § 74.43) that is no longer in effect. Nonetheless, DHS argues that the requirement that it "conduct open and free competitive procurements for Medicaid contracts remains." To support its position, DHS cites 45 C.F.R. § 75.326 (2022), which requires states procuring Medicaid contracts to "follow the same policies and procedures [the state] uses for procurements from its non-Federal funds." And DHS points to its own policy requiring "grants" to be "competitively awarded as much as possible."

In essence, DHS argues that it may not implement the CBP model without federal approval. *See Choate*, 469 U.S. at 289 n.1 (noting that states participating in Medicaid must comply with applicable regulations). Indeed, subdivision 9 clearly requires the DHS commissioner to request the federal waivers and approval "required to implement" the CBP statute. However, we are not prepared, on this record, to conclude that the federal government has withheld that approval or definitively stated that adhering to the unambiguous requirements of Minn. Stat. § 256B.69, subd. 3a(c), violates applicable regulations or statutes to such a degree that the federal government's "matching funds" for MA will be withheld. Therefore, we are not persuaded that subdivision 9 provides DHS grounds to ignore the plain language of Minn. Stat. § 256B.69, subd. 3a(c).

We are primarily guided by the lack of a clear denial of a DHS waiver request by the federal government pursuant to section 256B.692, subdivision 9. While DHS characterizes HCFA's December 1999 response as a denial of the waivers necessary to implement the CBP model established in part in section 256B.69, subdivision 3a(c), we fail to see how the response, which is over 20 years old and solely concerned EHP, can be read so broadly. Indeed, HCFA stated that the "issues" identified needed to "be resolved *before a decision* [could] be made on [DHS's] request." (Emphasis added.) Subsequent to the 1999 HCFA response, DHS began utilizing a competitive-bidding process, which appellants assert satisfies any requirements for competitive procurement. While we cannot say that the competitive-bidding process satisfies the federal government's concerns over competition, we likewise cannot say that CBP in its current form is improper. Under the

plain language of section 256B.692, subdivision 9, the federal government must give the requisite approval or clearly deny a waiver.

The record indicates that, to some degree, DHS has already implemented the CBP model. For example, DHS's deputy Medicaid director acknowledges in an affidavit that between 2001 and 2003 CMS "approved waivers for DHS to contract on a single-plan basis with two CBPs operating in rural areas of the state," South Country and PrimeWest.

Given the lack of a clear waiver denial and the fact that DHS has seemingly implemented CBP in the past, we are not prepared to override the plain language of section 256B.69, subdivision 3a(c), particularly since 45 C.F.R. § 74.43 is no longer in effect.

The second federal requirement that DHS argues conflicts with CBP single-source contracting is a single-state-agency requirement. DHS asserts that 42 C.F.R. § 431.10(b)(1) (2022)[9] requires that a single state agency administer and supervise MA, and DHS may not delegate the administration of MA to another entity, including local government, except for the purpose of Medicaid-eligibility determinations.

Given the lack of a clear waiver denial on this second basis, we are not prepared to override the plain language of section 256B.69, subdivision 3a(c).[10] Additionally, DHS's argument lacks textual support. Section 431.10(e) prohibits a state's "Medicaid agency"

[9] A state plan must "[s]pecify a single [s]tate agency established or designated to administer or supervise the administration of the plan." 42 C.F.R. § 431.10(b)(1).

[10] DHS's deputy Medicaid director asserted in an affidavit that he participated in a "telephone call with three CMS employees" who told DHS that they would not waive the requirement that a single state agency administer and supervise MA. We are not willing to override the plain language of section 256B.69, subdivision 3a(c) based on the telephone statements of unidentified CMS representatives.

from delegating "the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." 42 C.F.R. § 431.10(e) (2022). The regulation does not address what functions a state legislature may choose to delegate to a local government entity, so long as the state Medicaid agency retains the ability to supervise the administration of the program as a whole. Here, the Minnesota legislature—not DHS—has given the choice between CBP and PMAP to counties. Additionally, even assuming that section 431.10(e) applies to the actions of the legislature, the county-based purchasing system does not create a conflict because it does not involve a delegation of "the authority to supervise the plan or to develop or issue policies, rules, and regulations on program matters." *See id.* DHS retains those powers.

The third federal requirement that DHS argues conflicts with CBP single-source contracting is a choice-of-health-plan or choice-of-MCO requirement. *See* 42 U.S.C. § 1396u-2(a)(3)(A) (2018); 42 C.F.R. § 438.52(a) (2022). But again, given the lack of a clear waiver denial on this third basis, we are not prepared to override the plain language of section 256B.69, subdivision 3a(c). Additionally, the federal statute and the regulation allow states to limit enrollees to a single managed-care plan in "rural area[s]." 42 U.S.C. § 1396u-2(a)(3)(B) (2018); 42 C.F.R. § 438.52(b) (2022). The record indicates that appellants' member counties are rural counties.

DHS next argues that under Minn. Stat. § 256B.694, it has discretion to "contract with county-based purchasing plans on a single-plan basis in their member counties." Section 256B.694 states:

> The commissioner shall consider, and may approve, contracting on a single-health plan basis with county-based purchasing plans, or with other qualified health plans that have coordination arrangements with counties, to serve persons enrolled in state public health care programs, in order to promote better coordination or integration of health care services, social services and other community-based services, provided that all requirements applicable to health plan purchasing, including those in sections 256B.69 and 256B.692, are satisfied.

DHS argues that the discretion to approve CBP plans under the plain language of section 256B.694 trumps any requirement for single-source contracting in section 256B.69, subdivision 3a(c). Appellants argue that section 256B.69, subdivision 3a(c), and section 256B.694 do not conflict because there is a reasonable way to reconcile them, namely, section 256B.69, subdivision 3a(c), permits—but does not require—DHS to contract with both a CBP plan and one or more PMAP plans for a two-year period after the CBP entity begins to operate in a county.

Generally, we must construe statutes, if possible, to avoid irreconcilable differences. *D.W.H. ex rel. Mitchell v. Steele*, 494 N.W.2d 513, 515 (Minn. App. 1993), *aff'd*, 512 N.W.2d 586 (Minn. 1994); *see* Minn. Stat. § 645.26, subd. 1 (2022) ("When a general provision in a law is in conflict with a special provision in the same or another law, the two shall be construed, if possible, so that effect may be given to both."); *see also Nielsen v. 2003 Honda Accord*, 845 N.W.2d 754, 756-58 (Minn. 2013) (analyzing irreconcilability argument without determination of ambiguity). Generally, "a later law shall not be construed to repeal an earlier law unless the two laws are irreconcilable." Minn. Stat. § 645.39 (2022). Minnesota courts disfavor implied repeals and "will not imply a repeal

of a statute by a later enactment absent strong evidence that the two provisions are irreconcilable." *State v. Shifflet*, 556 N.W.2d 224, 227 (Minn. App. 1996). Two provisions are irreconcilable only if they are "necessarily inconsistent"—that is, they cannot "stand and be operative without repugnance to each other." *State v. City of Duluth*, 56 N.W.2d 416, 418 (Minn. 1952).

Under the plan language of the statutes, there is no irreconcilable conflict. Again, section 256B.69, subdivision 3a(c), states that if PMAP is in the county on or after September 1997, and the county wants to switch to CBP, DHS must terminate the PMAP contracts "if the county board submits and the commissioner accepts a preliminary and final proposal." But DHS "is not required to terminate contracts that begin" after September 1997 "until two years have elapsed from the date of initial enrollment." Minn. Stat. § 256B.69, subd. 3a(c). Appellants argue that section 256B.694 discusses this discretion to "terminate contracts." Appellants assert: "Read together with subdivision 3a(c), section 256B.694 requires the [c]ommissioner to at least consider single-plan contracts with CBPs even during that initial two-year period." We agree with appellants' proposed construction. The two statutes can be harmonized based on their plain language. We therefore need not examine the legislative history behind section 256B.694. *See Staab v. Diocese of St. Cloud*, 853 N.W.2d 713, 718 (Minn. 2014); *see also* Minn. Stat. § 645.16 (listing matters that may be considered when "the words of a law are not explicit").

Because under section 256B.69, subdivision 3a(c), DHS may not implement PMAP in a county that properly elects CBP, we reverse the district court's denial of summary judgment for appellants on counts I and III of appellants' complaint, which sought a

declaration that DHS's procurement process violated appellants' rights under that subdivision and an injunction on that basis. We likewise reverse the district court's grant of summary judgment for respondents on those counts. Appellants initially sought, under count III, "an injunction requiring DHS to revise, amend, or issue new RFPs that comply with state statute." Appellants, in their brief to this court, recognize that "[t]he passage of time has necessarily altered the nature of what injunctive relief would be appropriate" because "DHS ha[s] already completed its procurement process." Appellants acknowledge that "voiding DHS's unlawful contracts" could have "disruptive practical effects," and as such, appellants ask this court to remand to the district court to allow the parties "to work together toward a resolution that honors the rights of Minnesota counties while ensuring continuity of care for county residents," and to allow the district court to "reconsider appropriate injunctive relief." We agree that this is the appropriate disposition.

II.

Appellants next argue that under the requirements of section 256B.692, subdivisions 1 and 4, the commissioner must pay a county that provides health care under a CBP plan if the county's plan fulfills all relevant statutory and regulatory requirements.

Under section 256B.692, subdivision 1:

> County boards or groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for medical assistance who would otherwise be required to or may elect to participate in the prepaid medical assistance program according to section 256B.69. Counties that elect to purchase or provide health care under this section must provide all services included in prepaid managed care programs according to section 256B.69, subdivisions 1 to 22. County-based purchasing under this section is governed by

> section 256B.69, unless otherwise provided for under this section.

Under section 256B.692, subdivision 4, "The commissioner shall pay counties that are purchasing or providing health care under this section a per capita payment for all enrolled recipients."

Essentially, appellants argue that their counties plainly have statutory authority to elect CBP plans, and DHS does not have discretion to refuse a county's choice of CBP, so long as the county submits the requisite plan requirements and meets all other applicable requirements. *See* Minn. Stat. § 256B.692, subd. 5 (covering county preliminary and final proposals for CBP). Appellants recognize that CBP "must satisfy numerous federal and state requirements regarding financial solvency, the nature of benefits that must be provided, and other enrollee protections."

DHS argues that it only needs to pay for "enrolled recipients" under subdivision 4, and enrollment "is contingent on selection under an RFP and CMS contract approval." *See* 42 C.F.R. § 438.806 (2022) (covering federal financial participation under comprehensive risk contracts and requiring certain CMS approvals); *see also* Minn. Stat. § 256B.69, subds. 3a-5a (establishing process for procuring and awarding managed-care contracts). DHS effectively relies on its prior arguments that it has discretion to award a CBP contract and that it lacks necessary federal approval. For the reasons previously discussed, we reject these arguments.

Under the unambiguous language of subdivisions 1 and 4, DHS does not have discretion to refuse a county's choice of CBP, so long as the county makes a valid election

of CBP. Because under 256B.692, subdivisions 1 and 4, groups of county boards may elect to purchase or provide health care services on behalf of persons eligible for MA, and the DHS commissioner must pay counties that are purchasing or providing such health care, there are further grounds to reverse and remand as set forth in section I of this opinion.[11]

III.

Appellants argue that South Country and PrimeWest, as joint-powers entities, are entitled to mediate under Minn. Stat. § 256B.69, subd. 3a(d), because they constitute single entities representing a group of county boards. Appellants assert that IMCare is entitled to mediate under Minn. Stat. § 256B.69, subd. 3a(d) because it is effectively a county board.

Section 256B.69, subdivision 3a(d), states in relevant part:

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[11] Respondent Blue Plus argues that because MinnesotaCare prohibits single-source contracting, appellants are not entitled to single-source contracting in the form of CBP. *See* Minn. Stat. § 256L.121, subd. 3 (2022) (requiring the commissioner to coordinate administration of MinnesotaCare and MA "to maximize efficiency and improve the continuity of care"). MinnesotaCare—the state's basic health program established under the Affordable Care Act—provides health-care coverage to low-income individuals and families who do not qualify for Medicaid and otherwise lack access to health insurance. Minn. Stat. §§ 256L.02, .04, .07 (2022). State law requires DHS to follow a "competitive process" for entering into MinnesotaCare contracts. Minn. Stat. § 256L.121, subd. 1 (2022). Additionally, "to the extent feasible," the commissioner must make sure that enrollees have "a choice of coverage from more than one participating entity." *Id.*; *see also* 42 C.F.R. § 600.420(a)(1) (2022) (requiring states to "assure that standard health plans from at least two offerors are available" under MinnesotaCare). Neither section 256B.69, nor section 256B.692, contain a two-plan requirement. While section 256L.121, subdivision 1, requires competition among MinnesotaCare coverage providers "to the extent feasible," we decline to read into section 256L.121, subdivision 1, an irreconcilable conflict with sections 256B.69 and 256B.692. *See Steele*, 494 N.W.2d 515. Moreover, section 256L.121, subdivision 3(3), concerning the coordination of state-administered health programs, specifically directs the commissioner to comply with section 256B.69, subdivision 3a, and section 256B.692, subdivision 1, "when contracting with MinnesotaCare participating entities."

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

(Emphasis added.)

We first address IMCare, which appellants argue is effectively a county board because "[i]t is a division within the Health and Human Services Department of Itasca County" and "[t]he Itasca County board and the IMCare board are one and the same." Even accepting that IMCare and Itasca County's board are closely linked, there is a meaningful distinction between a county board and a division within a county department. Simply put, IMCare is not a county board. Under the unambiguous language of section 256B.69, subdivision 3a(d), IMCare is therefore not entitled to mediate. *See Larson*, 790 N.W.2d at 703. As DHS points out, Itasca County's board could, and did, request mediation in the 2022 RFP cycle.

As for South Country and PrimeWest, appellants assert that both can mediate because both entities were created by joint-powers agreements executed by their member counties. *See* Minn. Stat. § 471.59, subd. 1(a) (allowing governmental units to contract to exercise a common power). We agree. South Country and PrimeWest qualify under the unambiguous language of subdivision 3a(d).

South Country, by the terms of its joint-powers agreement, is an "entity" formed by a "group of Minnesota counties" for the purpose of "providing certain health programs and

services to eligible residents." South Country "is an entity empowered to act in its own right and on behalf of its Member Counties in the exercise of all powers delegated to it and its Member Counties" by the joint-powers agreement "and applicable law." Likewise, PrimeWest, by the terms of its joint-powers agreement, is an "entity" formed by "Member Counties" to "promote affordable access to health care services in rural Minnesota counties." As DHS stated in its 1999 waiver request, joint-powers boards "may exercise any power common to the contracting parties or any similar powers." Both South Country and PrimeWest clearly qualify as "a single entity representing a group of county boards" under subdivision 3a(d).

Moreover, appellants point to Minn. Stat. § 256B.69, subd. 3a(f), which states that "[t]he commissioner shall not require that contractual disputes between *county-based purchasing entities* and the commissioner be *mediated* by a panel that includes a representative of the Minnesota Council of Health Plans." (Emphasis added.) Appellants argue that this subdivision indicates "that the legislature understood the [c]ommissioner would mediate with CBPs, and in fact provided additional protections to ensure the fairness of that mediation for CBPs." We agree. We interpret statutes as a whole and consider a provision at issue "in light of the surrounding sections to avoid conflicting interpretations." *Am. Fam. Ins. Grp. v. Schroedl*, 616 N.W.2d 273, 277 (Minn. 2000). Under the unambiguous langue of section 256B.69, subdivision 3a(d), South Country and PrimeWest are entitled to mediate as "single entit[ies] representing a group of county boards."

Because an entity created by a joint-powers agreement, executed by its member counties to engage in county-based purchasing, is entitled to mediation as set forth in

subdivision 3a(d), we reverse the district court's denial of summary judgment for appellants on count II of appellants' complaint, which sought a declaration that South Country and PrimeWest are entitled to mediate under subdivision 3a(d), and we reverse the district court's grant of summary judgment for respondents on that count to the degree it concerns the rights of South Country and PrimeWest. We affirm the district court's decision as it relates to IMCare.

DECISION

We reverse in part and hold that DHS's procurement process violates appellants' rights under sections 256B.69 and 256B.692 and that South Country and PrimeWest are entitled to mediate. We affirm in part and hold that IMCare is not entitled to mediate. We remand to the district court for reconsideration of injunctive relief in light of this opinion.

Affirmed in part, reversed in part, and remanded.