State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 1873

March 8, 2007
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The bill was read for the first time and referred to the Committee on Health and Human Services

A bill for an act

relating to health; requiring annual reports on cost containment goals; establishing a medical expenditure review committee; establishing a health care transformation task force; modifying goals for universal coverage; requiring written hospital charity care policies; modifying performance payments for medical groups; requiring a payment reform plan; providing grants for community collaboratives; requiring a contract for nonprofit organization accountability; appropriating money; amending Minnesota Statutes 2006, sections 62J.04, subdivision 3; 62J.17, subdivision 6a, by adding a subdivision; 62Q.165, subdivisions 1, 2; 144.56, by adding a subdivision; 256.01, subdivision 2b; proposing coding for new law in Minnesota Statutes, chapter 62J.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

Section 1. Minnesota Statutes 2006, section 62J.04, subdivision 3, is amended to read:

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section ~~and~~, collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals, and annually report to the legislature on whether the goals were achieved and, if not, what action should be taken to ensure that goals are achieved in the future;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne Counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

(6) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(8) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 2. Minnesota Statutes 2006, section 62J.17, subdivision 6a, is amended to read:

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence and the report and recommendations of the Minnesota Medical Expenditure Review

Committee, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 3. Minnesota Statutes 2006, section 62J.17, is amended by adding a subdivision to read:

Subd. 6b. **Minnesota Medical Expenditure Review Committee.** (a) The Minnesota Medical Expenditure Review Committee is established as a permanent advisory committee to the commissioner of health to act as a consumer voice in the review of major spending commitments under this section. At least two-thirds of the members of the committee must be individual members as defined in clause (6). The committee consists of:

(1) the commissioner of health;

(2) the commissioner of employee relations;

(3) the commissioner of human services;

(4) five persons representing employers and other health care purchasers from the public and private sectors, including at least two representing large employers and at least one representing small employers, provided that no purchaser representative appointed under this clause may be a health care professional or employee or board member of a health care organization or insurer;

(5) three experts qualified to assess the impact of major health care expenditures on the community, including one from an academic institution, one representing a health care provider organization, and one representing a health plan company; and

(6) individuals who are not health care professionals, are not employed in a health-care-related position, and do not have a direct financial interest in a health-care-related organization, including one who has health coverage through a large employer, one who has health coverage through a small employer, one who purchases health coverage in the individual market, one who is uninsured, and one who receives coverage through a government program.

(b) The committee is governed by section 15.059, except that the committee does not expire and members receive reimbursement only for expenses.

(c) The committee shall collect statewide information that can inform consumers on major spending commitments and their impact on costs, quality, and access. The committee shall make recommendations to the commissioner on: what information should be required from all providers seeking to make a major spending commitment, reporting thresholds, and information and data requirements that contribute to quality measurement.

(d) The committee shall study and report to the commissioner and the legislature on medical services that are currently available in medical facilities and the capacity and use of existing medical facilities.

EFFECTIVE DATE. This section is effective the day following final enactment.

Sec. 4. **[62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**

Subdivision 1. **Task force.** The Health Care Transformation Task Force consists of:

(1) the Legislative Commission on Health Care Access established under section 62J.07;

(2) the commissioners of human services, health, and commerce;

(3) four persons designated by the SmartBuy alliance to represent private sector purchasers, including one representing public employers, one representing large employers, one representing small employers, and one representing labor unions; and

(4) six persons designated by the partnership for action to transform health care, a multisector policy alliance of hospitals and health systems, health plan companies, physicians, and other health care organizations.

Subd. 2. **Public input.** The commissioner of health shall review available research and conduct statewide, regional, and local surveys, focus groups, and other activities to determine Minnesotans' values, preferences, opinions, and perceptions related to health care and to the issues confronting the task force, and shall report the findings to the task force.

Subd. 3. **Inventory and assessment of existing activities.** The task force shall complete an inventory and assessment of all public and private organized activities, coalitions, and collaboratives working on tasks relating to health system improvement including, but not limited to, patient safety, quality measurement and reporting, evidence-based practice, adoption of health information technology, disease management and chronic care coordination, medical homes, access to health care, cultural competence, prevention and public health, consumer incentives, price and cost transparency, nonprofit organization community benefits, education, research, and health care workforce. By December 15, 2007, the task force shall present recommendations to the legislature, the governor, and to those working on these activities on how these activities may be made more effective and how coordination and communication may be improved.

Subd. 4. **Action plan.** By December 15, 2007, the task force shall develop and present, to the legislature and the governor, a statewide action plan for transforming the health care system to improve affordability, quality, and access. The plan may consist of legislative actions, administrative actions of governmental entities, collaborative actions, and actions of individuals and individual organizations. The plan must include specific and measurable goals and deadlines for affordability, quality, and access. The plan must include a method of coordination and communication among the activities identified under subdivision 3.

Sec. 5. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

Subdivision 1. **Definition.** It is the commitment of the state to achieve universal health coverage for all Minnesotans by the year 2010. Universal coverage is achieved when:

(1) every Minnesotan has access to a full range of quality health care services;

(2) every Minnesotan is able to obtain affordable health coverage which pays for the full range of services, including preventive and primary care; and

(3) every Minnesotan pays into the health care system according to that person's ability.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 6. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward reducing the number of Minnesotans who do not have health coverage so that by January 1, ~~2000, fewer than four percent of the state's population will be without health coverage~~ 2010, all Minnesota residents have access to affordable health care. The goal will be achieved by improving access to private health coverage through insurance reforms and market reforms, by making health coverage more affordable for low-income Minnesotans through purchasing pools and state subsidies, and by reducing the cost of health coverage through cost containment programs and methods of ensuring that all Minnesotans are paying into the system according to their ability.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 7. Minnesota Statutes 2006, section 144.56, is amended by adding a subdivision to read:

Subd. 5. **Charity care and uncompensated care policies; rules on debt collection.** The commissioner shall require all hospitals licensed under this chapter to maintain a written charity care policy, make the policy available to the public by posting it in public areas of the hospital and on hospital Web sites, and provide information on charity care policies and state public insurance programs to uninsured patients. The commissioner shall adopt rules establishing standardized debt collection practices for hospitals.

EFFECTIVE DATE. This section is effective August 1, 2008.

Sec. 8. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

Subd. 2b. **Performance payments.** (a) The commissioner shall develop and implement a pay-for-performance system to provide performance payments to:

(1) medical groups that demonstrate optimum care in serving individuals with chronic diseases who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L; and

(2) medical groups that implement effective medical home models of patient care that improve quality and reduce costs through effective primary and preventive care, care coordination, and management of chronic conditions.

(b) The commissioner shall also develop and implement a patient incentive health program to provide incentives and rewards to patients who are enrolled in health care programs administered by the commissioner under chapters 256B, 256D, and 256L, and who have agreed to and meet personal health goals established with their primary care provider to manage a chronic disease or condition including, but not limited to, diabetes, high blood pressure, and coronary artery disease.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 9. **HEALTH CARE PAYMENT SYSTEM REFORM.**

Subdivision 1. **Payment reform plan.** The commissioners of employee relations, human services, commerce, and health shall develop a plan for promoting and facilitating changes in payment rates and methods for paying for health care services, drugs, devices, supplies, and equipment in order to:

(1) reward the provision of cost-effective primary and preventive care;

(2) reward the use of evidence-based care;

(3) discourage overuse and misuse;

(4) reward the use of the most cost-effective settings, drugs, devices, providers, and treatments; and

(5) encourage consumers to maintain good health and use the health care system appropriately.

Subd. 2. **Report.** The commissioners shall submit a report to the legislature by December 15, 2007, describing the payment reform plan. The report must include proposed legislation for implementing those components of the plan requiring legislative action or appropriations of money.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 10. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER THE UNINSURED.**

Subdivision 1. **Community collaboratives.** The commissioner of health shall provide grants to and authorization for up to three community collaboratives that satisfy the requirements in this section. To be eligible to receive a grant and authorization under this section, a community collaborative must include:

(1) one or more counties;

(2) one or more local hospitals;

(3) one or more local employers who collectively provide at least 300 jobs in the community;

(4) one or more health care clinics or physician groups; and

(5) a third-party payer, which may be a county-based purchasing plan operating under Minnesota Statutes, section 256B.692, a self-insured employer, or a health plan company as defined in Minnesota Statutes, section 62Q.01, subdivision 4.

Subd. 2. **Pilot project requirements.** (a) Community collaborative pilot projects must:

(1) identify and enroll persons in the community who are uninsured, and who have, or are at risk of developing, one of the following chronic conditions: mental illness, diabetes, asthma, hypertension, or other chronic condition designated by the project;

(2) assist uninsured persons obtain private-sector health insurance coverage if possible or enroll in any public health care programs for which they are eligible. If the uninsured individual is unable to obtain health coverage, the community collaborative must enroll the individual in a local health care assistance program that provides specified services to prevent or effectively manage the chronic condition;

(3) include components to help uninsured persons retain employment or to become employable, if currently unemployed;

(4) ensure that each uninsured person enrolled in the program has a medical home responsible for providing, or arranging for, health care services and assisting in the effective management of the chronic condition;

(5) coordinate services between all providers and agencies serving an enrolled individual; and

(6) be coordinated with the state's Q-Care initiative and improve the use of evidence-based treatments and effective disease management programs in the broader community, beyond those individuals enrolled in the project.

(b) Projects established under this section are not insurance and are not subject to state-mandated benefit requirements or insurance regulations.

Subd. 3. **Criteria.** Proposals must be evaluated by actuarial, financial, and clinical experts based on the likelihood that the project would produce a positive return on investment for the community. In awarding grants, the commissioner of health shall give preference to proposals that:

(1) have broad community support from local businesses, provider counties, and other public and private organizations;

(2) would provide services to uninsured persons who have, or are at risk of developing, multiple, co-occurring chronic conditions;

(3) integrate or coordinate resources from multiple sources, such as employer contributions, county funds, social service programs, and provider financial or in-kind support;

(4) provide continuity of treatment and services when uninsured individuals in the program become eligible for public or private health insurance or when insured individuals lose their coverage;

(5) demonstrate how administrative costs for health plan companies and providers can be reduced through greater simplification, coordination, consolidation, standardization, reducing billing errors, or other methods; and

(6) involve local contributions to the cost of the pilot projects.

Subd. 4. **Grants.** The commissioner of health shall provide implementation grants of up to one-half of the community collaborative's costs for planning, administration, and evaluation. The commissioner shall also provide grants to community collaboratives to develop a fund to pay up to 50 percent of the cost of the services provided to uninsured individuals. The remaining costs must be paid for through other sources or by agreement of a health care provider to contribute the cost as charity care.

Subd. 5. **Evaluation.** The commissioner of health shall evaluate the effectiveness of each community collaborative project awarded a grant, by comparing actual costs for serving the identified uninsured persons to the predicted costs that would have been incurred in the absence of early intervention and consistent treatment to manage the chronic condition, including the costs to medical assistance, MinnesotaCare, and general assistance medical care. The commissioner shall require community collaborative projects, as a condition of receipt of a grant award, to provide the commissioner with all information necessary for this evaluation.

EFFECTIVE DATE. This section is effective July 1, 2007.

Sec. 11. **NONPROFIT ORGANIZATION COMMUNITY BENEFIT AND ACCOUNTABILITY.**

The commissioner of health shall award a contract to a private organization with the capacity to convene leaders of health care, business, government, and consumer groups for the development of standards and guidelines for nonprofit health care organization community benefit programs, reporting, and public accountability. The organization must:

(1) develop and test a model, standardized system for nonprofit health care organizations to track, quantify, and report on the financial value of benefits provided by a nonprofit organization to the community including, but not limited to, uncompensated

care provided to uninsured patients and the outcome and effectiveness of community benefit programs;

(2) develop guidelines for nonprofit health care organization boards, executives, and staff to ensure that the nonprofit organization acts in the best interests of the community;

(3) develop written training materials and training curriculum on the model and guidelines; and

(4) submit a preliminary report to the commissioner of health and the legislature by January 1, 2008, and a final report by January 1, 2009.

Sec. 12. **APPROPRIATIONS.**

(a) $..... is appropriated from the general fund to the commissioner of human services for the biennium beginning July 1, 2007, to provide performance payments under Minnesota Statutes, section 256.01, subdivision 2b.

(b) $..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2007, to provide grants to community collaboratives under section 10.

(c) $..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2007, for a contract related to nonprofit organization accountability under section 11.

(d) $..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2007, for purposes of conducting prospective reviews and for the costs of the Minnesota Medical Expenditure Review Committee under sections 2 and 3.

(e) $..... is appropriated from the general fund to the commissioner of health for the biennium beginning July 1, 2007, to establish the Health Care Transformation Task Force under Minnesota Statutes, section 62J.84.