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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. 1873

March 8, 2007

Authored by Bunn, Huntley, Thissen, Abeler, Lenczewski and others
The bill was read for the first time and referred to the Committee on Health and Human Services

March 19, 2007

Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Governmental Operations, Reform, Technology and Elections

March 27, 2007

Committee Recommendation and Adoption of Report:
To Pass and re-referred to the Committee on Finance

1.1 A bill for an act
1.2 relating to health; requiring annual reports on cost containment goals;
1.3 establishing a health care transformation task force; modifying goals for
1.4 universal coverage; establishing a demonstration project for community-based
1.5 health care initiative; modifying performance payments for medical groups;
1.6 requiring a physician-directed care coordination program; requiring a payment
1.7 reform plan; providing grants for community collaboratives; establishing health
1.8 care payment reform pilot projects; requiring a study; appropriating money;
1.9 amending Minnesota Statutes 2006, sections 62J.04, subdivision 3; 62J.81,
1.10 subdivision 1; 62Q.165, subdivisions 1, 2; 62Q.80, subdivisions 3, 4, 13,
1.11 14, by adding a subdivision; 256.01, subdivision 2b; 256B.0625, by adding a
1.12 subdivision; proposing coding for new law in Minnesota Statutes, chapter 62J;
1.13 repealing Minnesota Statutes 2006, section 62J.052, subdivision 1.

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

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

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

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

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

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

2.1 (4) issue recommendations regarding uniform billing forms, uniform electronic
 2.2 billing procedures and data interchanges, patient identification cards, and other uniform
 2.3 claims and administrative procedures for health care providers and private and public
 2.4 sector payers. In developing the recommendations, the commissioner shall review the
 2.5 work of the work group on electronic data interchange (WEDI) and the American National
 2.6 Standards Institute (ANSI) at the national level, and the work being done at the state and
 2.7 local level. The commissioner may adopt rules requiring the use of the Uniform Bill
 2.8 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic
 2.9 version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized
 2.10 forms or procedures;

2.11 (5) undertake health planning responsibilities;

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

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

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

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

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

2.26 Sec. 2. Minnesota Statutes 2006, section 62J.81, subdivision 1, is amended to read:

2.27 Subdivision 1. **Required disclosure of estimated payment.** (a) A health care
 2.28 provider, as defined in section 62J.03, subdivision 8, or the provider's designee as agreed
 2.29 to by that designee, shall, at the request of a consumer, provide that consumer with a good
 2.30 faith estimate of the ~~reimbursement~~ allowable payment the provider ~~expects to receive~~
 2.31 ~~from the health plan company in which the consumer is enrolled~~ has agreed to accept from
 2.32 the consumer's health plan company for the services specified by the consumer, specifying
 2.33 the amount of the allowable payment due from the health plan company. Health plan
 2.34 companies must allow contracted providers, or their designee, to release this information.
 2.35 ~~A good faith estimate must also be made available at the request of a consumer who~~

3.1 ~~is not enrolled in a health plan company.~~ If a consumer has no applicable public or
 3.2 private coverage, the health care provider must give the consumer a good faith estimate
 3.3 of the average allowable reimbursement the provider accepts as payment from private
 3.4 third-party payers for the services specified by the consumer and the estimated amount
 3.5 the noncovered consumer will be required to pay. Payment information provided by a
 3.6 provider, or by the provider's designee as agreed to by that designee, to a patient pursuant
 3.7 to this subdivision does not constitute a legally binding estimate of the allowable charge
 3.8 for or cost to the consumer of services.

3.9 (b) A health plan company, as defined in section 62J.03, subdivision 10, shall, at
 3.10 the request of an enrollee or the enrollee's designee, provide that enrollee with a good
 3.11 faith estimate of the ~~reimbursement~~ allowable amount the health plan company ~~would~~
 3.12 ~~expect to pay to~~ has contracted for with a specified provider within the network as total
 3.13 payment for a health care service specified by the enrollee and the portion of the allowable
 3.14 amount due from the enrollee and the enrollee's out-of-pocket costs. ~~If requested by the~~
 3.15 ~~enrollee, the health plan company shall also provide to the enrollee a good faith estimate~~
 3.16 ~~of the enrollee's out-of-pocket cost for the health care service.~~ An estimate provided to
 3.17 an enrollee under this paragraph is not a legally binding estimate of the ~~reimbursement~~
 3.18 allowable amount or enrollee's out-of-pocket cost.

3.19 **EFFECTIVE DATE.** This section is effective August 1, 2007.

3.20 **Sec. 3. [62J.84] HEALTH CARE TRANSFORMATION TASK FORCE.**

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

3.22 (1) the Legislative Commission on Health Care Access established under section
 3.23 62J.07;

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

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

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

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

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

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

4.20 Sec. 4. Minnesota Statutes 2006, section 62Q.165, subdivision 1, is amended to read:

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

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

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

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

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

4.30 Sec. 5. Minnesota Statutes 2006, section 62Q.165, subdivision 2, is amended to read:

4.31 Subd. 2. **Goal.** It is the goal of the state to make continuous progress toward
4.32 reducing the number of Minnesotans who do not have health coverage so that by January
4.33 1, 2000, ~~fewer than four percent of the state's population will be without health coverage~~
4.34 2010, all Minnesota residents have access to affordable health care. The goal will be

5.1 achieved by improving access to private health coverage through insurance reforms and
5.2 market reforms, by making health coverage more affordable for low-income Minnesotans
5.3 through purchasing pools and state subsidies, and by reducing the cost of health coverage
5.4 through cost containment programs and methods of ensuring that all Minnesotans are
5.5 paying into the system according to their ability.

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

5.7 Sec. 6. Minnesota Statutes 2006, section 62Q.80, is amended by adding a subdivision
5.8 to read:

5.9 **Subd. 1a. Demonstration project.** The commissioner of health shall award a
5.10 demonstration project grant to a community-based health care initiative to develop and
5.11 operate a community-based health care coverage program to operate within Carlton,
5.12 Cook, Lake, and St. Louis Counties. The demonstration project shall extend for five years
5.13 and must comply with all the requirements of this section.

5.14 Sec. 7. Minnesota Statutes 2006, section 62Q.80, subdivision 3, is amended to read:

5.15 **Subd. 3. Approval.** (a) Prior to the operation of a community-based health care
5.16 coverage program, a community-based health initiative shall submit to the commissioner
5.17 of health for approval the community-based health care coverage program developed by
5.18 the initiative. ~~The commissioner shall only approve a program that has been awarded~~
5.19 ~~a community access program grant from the United States Department of Health and~~
5.20 ~~Human Services.~~ The commissioner shall ensure that the program meets the federal grant
5.21 requirements and any requirements described in this section and is actuarially sound based
5.22 on a review of appropriate records and methods utilized by the community-based health
5.23 initiative in establishing premium rates for the community-based health care coverage
5.24 program.

5.25 (b) Prior to approval, the commissioner shall also ensure that:

5.26 (1) the benefits offered comply with subdivision 8 and that there are adequate
5.27 numbers of health care providers participating in the community-based health network to
5.28 deliver the benefits offered under the program;

5.29 (2) the activities of the program are limited to activities that are exempt under this
5.30 section or otherwise from regulation by the commissioner of commerce;

5.31 (3) the complaint resolution process meets the requirements of subdivision 10; and

5.32 (4) the data privacy policies and procedures comply with state and federal law.

5.33 Sec. 8. Minnesota Statutes 2006, section 62Q.80, subdivision 4, is amended to read:

6.1 Subd. 4. **Establishment.** (a) The initiative shall establish and operate upon approval
 6.2 by the commissioner of health a community-based health care coverage program. The
 6.3 operational structure established by the initiative shall include, but is not limited to:

- 6.4 (1) establishing a process for enrolling eligible individuals and their dependents;
- 6.5 (2) collecting and coordinating premiums from enrollees and employers of enrollees;
- 6.6 (3) providing payment to participating providers;
- 6.7 (4) establishing a benefit set according to subdivision 8 and establishing premium
 6.8 rates and cost-sharing requirements;
- 6.9 (5) creating incentives to encourage primary care and wellness services; and
- 6.10 (6) initiating disease management services, as appropriate.

6.11 ~~(b) The payments collected under paragraph (a), clause (2), may be used to capture~~
 6.12 ~~available federal funds.~~

6.13 Sec. 9. Minnesota Statutes 2006, section 62Q.80, subdivision 13, is amended to read:

6.14 Subd. 13. **Report.** (a) The initiative shall submit quarterly status reports to the
 6.15 commissioner of health on January 15, April 15, July 15, and October 15 of each year,
 6.16 with the first report due January 15, ~~2007~~ 2008. The status report shall include:

- 6.17 (1) the financial status of the program, including the premium rates, cost per member
 6.18 per month, claims paid out, premiums received, and administrative expenses;
- 6.19 (2) a description of the health care benefits offered and the services utilized;
- 6.20 (3) the number of employers participating, the number of employees and dependents
 6.21 covered under the program, and the number of health care providers participating;
- 6.22 (4) a description of the health outcomes to be achieved by the program and a status
 6.23 report on the performance measurements to be used and collected; and
- 6.24 (5) any other information requested by the commissioner of health or commerce or
 6.25 the legislature.

6.26 (b) The initiative shall contract with an independent entity to conduct an evaluation
 6.27 of the program to be submitted to the commissioners of health and commerce and the
 6.28 legislature by January 15, ~~2009~~ 2010. The evaluation shall include:

- 6.29 (1) an analysis of the health outcomes established by the initiative and the
 6.30 performance measurements to determine whether the outcomes are being achieved;
- 6.31 (2) an analysis of the financial status of the program, including the claims to
 6.32 premiums loss ratio and utilization and cost experience;
- 6.33 (3) the demographics of the enrollees, including their age, gender, family income,
 6.34 and the number of dependents;

7.1 (4) the number of employers and employees who have been denied access to the
7.2 program and the basis for the denial;

7.3 (5) specific analysis on enrollees who have aggregate medical claims totaling over
7.4 \$5,000 per year, including data on the enrollee's main diagnosis and whether all the
7.5 medical claims were covered by the program;

7.6 (6) number of enrollees referred to state public assistance programs;

7.7 (7) a comparison of employer-subsidized health coverage provided in a comparable
7.8 geographic area to the designated community-based geographic area served by the
7.9 program, including, to the extent available:

7.10 (i) the difference in the number of employers with 50 or fewer employees offering
7.11 employer-subsidized health coverage;

7.12 (ii) the difference in uncompensated care being provided in each area; and

7.13 (iii) a comparison of health care outcomes and measurements established by the
7.14 initiative; and

7.15 (8) any other information requested by the commissioner of health or commerce.

7.16 Sec. 10. Minnesota Statutes 2006, section 62Q.80, subdivision 14, is amended to read:

7.17 Subd. 14. **Sunset.** This section expires December 31, ~~2011~~ 2012.

7.18 Sec. 11. Minnesota Statutes 2006, section 256.01, subdivision 2b, is amended to read:

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

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

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

7.27 (3) eligible medical groups and clinics that evaluate medical provider usage patterns
7.28 and provide feedback to individual medical providers on that provider's practice patterns
7.29 relative to peer medical providers.

7.30 (b) The commissioner shall also develop and implement a patient incentive health
7.31 program to provide incentives and rewards to patients who are enrolled in health care
7.32 programs administered by the commissioner under chapters 256B, 256D, and 256L, and
7.33 who have agreed to and meet personal health goals established with their primary care

8.1 provider to manage a chronic disease or condition including, but not limited to, diabetes,
8.2 high blood pressure, and coronary artery disease.

8.3 (c) The commissioner may receive any federal matching money that is made
8.4 available through the medical assistance program for managed care oversight contracted
8.5 through vendors including consumer surveys, studies, and external quality reviews as
8.6 required by the Federal Balanced Budget Act of 1997, Code of Federal Regulations,
8.7 title 42, part 438, subpart E. Any federal money received for managed care oversight is
8.8 appropriated to the commissioner for this purpose. The commissioner may expend the
8.9 federal money received in either year of the biennium.

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

8.11 Sec. 12. Minnesota Statutes 2006, section 256B.0625, is amended by adding a
8.12 subdivision to read:

8.13 **Subd. 49. Physician-directed care coordination services.** The commissioner
8.14 shall develop and implement a physician-directed care coordination program for medical
8.15 assistance recipients who are not enrolled in the prepaid medical assistance program and
8.16 who are receiving services on a fee-for-service basis. This program provides payment
8.17 to primary care clinics for care coordination for people who have complex and chronic
8.18 medical conditions. Clinics must meet certain criteria such as the capacity to develop care
8.19 plans; have a dedicated care coordinator; and have an adequate number of fee-for-service
8.20 clients, evaluation mechanisms, and quality improvement processes to qualify for
8.21 reimbursement.

8.22 Sec. 13. **HEALTH CARE PAYMENT SYSTEM REFORM.**

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

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

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

8.29 (3) discourage underutilization, overuse, and misuse;

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

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

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

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

9.6 Sec. 14. **COMMUNITY COLLABORATIVE PILOT PROJECTS TO COVER**
9.7 **THE UNINSURED.**

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

9.12 (1) one or more counties;

9.13 (2) one or more local hospitals;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10.32 Subd. 5. **Evaluation.** The commissioner of health shall evaluate the effectiveness
10.33 of each community collaborative project awarded a grant, by comparing actual costs
10.34 for serving the identified uninsured persons to the predicted costs that would have
10.35 been incurred in the absence of early intervention and consistent treatment to manage
10.36 the chronic condition, including the costs to medical assistance, MinnesotaCare, and

11.1 general assistance medical care. The commissioner shall require community collaborative
11.2 projects, as a condition of receipt of a grant award, to provide the commissioner with all
11.3 information necessary for this evaluation.

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

11.5 Sec. 15. **HEALTH CARE PAYMENT REFORM PILOT PROJECTS.**

11.6 Subdivision 1. **Pilot projects.** (a) The commissioners of health, human services,
11.7 and employee relations shall develop and administer payment reform pilot projects for
11.8 state employees and persons enrolled in medical assistance, MinnesotaCare, or general
11.9 assistance medical care, to the extent permitted by federal requirements. The purpose of
11.10 the projects is to promote and facilitate changes in payment rates and methods for paying
11.11 for health care services, drugs, devices, supplies, and equipment in order to:

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

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

11.14 (3) reward coordination of care for patients with chronic conditions;

11.15 (4) discourage overuse and misuse;

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

11.18 (6) encourage consumers to maintain good health and use the health care system
11.19 appropriately.

11.20 (b) The pilot projects must involve the use of designated care professionals or
11.21 clinics to serve as a patient's medical home and be responsible for coordinating health
11.22 care services across the continuum of care. The pilot projects must evaluate different
11.23 payment reform models and must be coordinated with the Minnesota senior health options
11.24 program and the Minnesota disability health options program. To the extent possible, the
11.25 commissioners shall coordinate state purchasing activities with other public employers
11.26 and with private purchasers, self-insured groups, and health plan companies to promote
11.27 the use of pilot projects encompassing both public and private purchasers and markets.

11.28 Subd. 2. **Payment methods and incentives.** The commissioners shall modify
11.29 existing payment methods and rates for those enrollees and health care providers
11.30 participating in the pilot project in order to provide incentives for care management,
11.31 team-based care, and practice redesign, and increase resources for primary care, chronic
11.32 condition care, and care provided to complex patients. The commissioners may create
11.33 financial incentives for patients to select a medical home under the pilot project by
11.34 reducing, modifying, or eliminating deductibles and co-payments for certain services, or
11.35 through other incentives. The commissioners may require patients to remain with their

12.1 designated medical home for a specified period of time. Alternative payment methods
12.2 may include complete or partial capitation, fee-for-service payments, or other payment
12.3 methodologies. The payment methods may provide for the payment of bonuses to medical
12.4 home providers or other providers, or to patients, for the achievement of performance
12.5 goals. The payment methods may include allocating a portion of the payment that
12.6 would otherwise be paid to health plans under state prepaid health care programs to the
12.7 designated medical home for specified services.

12.8 Subd. 3. **Requirements.** In order to be designated a medical home under the pilot
12.9 project, health care professionals or clinics must demonstrate their ability to:

12.10 (1) be the patient's first point of contact 24 hours a day, seven days a week;

12.11 (2) provide or arrange for patients' comprehensive health care needs, including the
12.12 ability to structure planned chronic disease visits and to manage chronic disease through
12.13 the use of disease registries;

12.14 (3) coordinate patients' care when care must be provided outside the medical home;

12.15 (4) provide longitudinal care, not just episodic care, including meeting long-term
12.16 and unique personal needs;

12.17 (5) utilize an electronic health record and incorporate a plan to develop and make
12.18 available to patients that choose a medical home an electronic personal health record that
12.19 is prepopulated with the patient's data, consumer-directed, connected to the provider,
12.20 24-hour accessible, and owned and controlled by the patient;

12.21 (6) systematically improve quality of care using, among other inputs, patient
12.22 feedback; and

12.23 (7) create a provider network that provides for increased reimbursement for a
12.24 medical home in a cost-neutral manner.

12.25 Subd. 4. **Evaluation.** Pilot projects must be evaluated based on patient satisfaction,
12.26 provider satisfaction, clinical process and outcome measures, program costs and savings,
12.27 and economic impact on health care providers. Pilot projects must be evaluated based
12.28 on the extent to which the medical home:

12.29 (1) coordinated health care services across the continuum of care and thereby
12.30 reduced duplication of services and enhanced communication across providers;

12.31 (2) provided safe and high-quality care by increasing utilization of effective
12.32 treatments, reduced use of ineffective treatments, reduced barriers to essential care and
12.33 services, and eliminated barriers to access;

12.34 (3) reduced unnecessary hospitalizations and emergency room visits and increased
12.35 use of cost-effective care and settings;

13.1 (4) encouraged long-term patient and provider relationships by shifting from
13.2 episodic care to consistent, coordinated communication and care with a specified team of
13.3 providers or individual providers;

13.4 (5) engaged and educated consumers by encouraging shared patient and provider
13.5 responsibility and accountability for disease prevention, health promotion, chronic
13.6 disease management, acute care, and overall well-being, encouraging informed medical
13.7 decision-making, ensuring the availability of accurate medical information, and facilitated
13.8 the transfer of accurate medical information;

13.9 (6) encouraged innovation in payment methodologies by using patient and provider
13.10 incentives to coordinate care and utilize medical home services and fostering the
13.11 expansion of a technology infrastructure that supports collaboration; and

13.12 (7) reduced overall health care costs as compared to conventional payment methods
13.13 for similar patient populations.

13.14 Subd. 5. **Rulemaking.** The commissioners are exempt from administrative
13.15 rulemaking under chapter 14 for purposes of developing, administering, contracting
13.16 for, and evaluating pilot projects under this section. The commissioner shall publish a
13.17 proposed request for proposals in the State Register and allow 30 days for comment
13.18 before issuing the final request for proposals.

13.19 Subd. 6. **Regulatory and payment barriers.** The commissioners shall study state
13.20 and federal statutory and regulatory barriers to the creation of medical homes and provide
13.21 a report and recommendations to the legislature by December 15, 2007.

13.22 **Sec. 16. HEALTH CARE SYSTEM CONSOLIDATION.**

13.23 The commissioner of health shall study the effect of health care provider and health
13.24 plan company consolidation in the four metropolitan statistical areas in Minnesota on:
13.25 health care costs, including provider payment rates; quality of care; and access to care.
13.26 The commissioner shall separately consider hospitals, specialty groups, and primary care
13.27 groups. The commissioner shall present findings and recommendations to the legislature
13.28 by December 15, 2007.

13.29 **Sec. 17. APPROPRIATIONS.**

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

14.1 (b) \$..... is appropriated from the general fund to the commissioner of health for
14.2 the biennium beginning July 1, 2007, to provide grants to community collaboratives
14.3 under section 14.

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

14.7 (d) \$1,050,000 is appropriated for the biennium beginning July 1, 2007, from the
14.8 general fund to the commissioner of health for the demonstration project grant described
14.9 in Minnesota Statutes, section 62Q.80, subdivision 1a. This is a onetime appropriation
14.10 and is available until June 30, 2012.

14.11 (e) \$..... for the fiscal year ending June 30, 2008, and \$..... for the fiscal year
14.12 ending June 30, 2009, are appropriated from the general fund to the commissioner of
14.13 health for the medical education and research fund administered under Minnesota Statutes,
14.14 section 62J.692, to expand multidisciplinary education and training programs and primary
14.15 care education initiatives, to maintain Minnesota's primary care workforce capacity.

14.16 (f) \$..... for the fiscal year ending June 30, 2008, and \$..... for the fiscal year
14.17 ending June 30, 2009, are appropriated to the commissioner of health to work with
14.18 institutions of higher education to establish or fund existing initiatives to recruit and
14.19 retain nurse educators in nursing education programs, in order to expand the educational
14.20 capacity needed to address Minnesota's nursing shortage.

14.21 **Sec. 18. REPEALER.**

14.22 Minnesota Statutes 2006, section 62J.052, subdivision 1, is repealed effective
14.23 August 1, 2007.

APPENDIX
Repealed Minnesota Statutes: H1873-1

62J.052 PROVIDER COST DISCLOSURE.

Subdivision 1. **Health care providers.** (a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals and outpatient surgical centers subject to the requirements of section 62J.823, shall provide the following information:

(1) the average allowable payment from private third-party payers for the 50 services or procedures most commonly performed;

(2) the average payment rates for those services and procedures for medical assistance;

(3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and

(4) the average charge for those services and procedures, including all patients.

(b) This information shall be updated annually and be readily available at no cost to the public on site.