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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-SEVENTH SESSION

H. F. No. 2230

02/13/2012 Authored by Abeler and Huntley

The bill was read for the first time and referred to the Committee on Health and Human Services Reform

02/16/2012 By motion, recalled and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to human services; providing pediatric care coordination services; requiring demonstration providers to include in provider networks all providers that agree to standard contract terms; requiring patient-centered decision making under all medical assistance for certain procedures; requiring managed care and county-based purchasing plans to reduce the incidence of low birth weight; establishing a competitive bidding program for the seven-county metropolitan area; requiring the commissioner of human services to report on a draft methodology to allow the release of certain health data to research institutions; amending Minnesota Statutes 2010, sections 256B.0625, by adding a subdivision; 256B.69, subdivisions 6, 9, by adding subdivisions; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. Minnesota Statutes 2010, section 256B.0625, is amended by adding a subdivision to read:

Subd. 51a. Pediatric care coordination. The commissioner shall develop and implement a pediatric care coordination program for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services on a fee-for-service basis. In developing the pediatric care coordination program, the commissioner shall consider incorporating features of the U Special Kids Program operated by the University of Minnesota Department of Pediatrics. Care coordination services must be provided by care coordinators employed by or under contract with the commissioner and must be targeted to children admitted to hospitals that do not currently provide care coordination services. For purposes of this subdivision, "care coordination" means collaboration between the patient and patient's family, the hospital, and providers of health care and psychiatric services to manage patient care and reduce

2.1 unnecessary emergency room use and hospitalization, minimize medical and psychiatric
 2.2 complications, streamline and improve communication and access to patient care
 2.3 management information, and develop and promote patient compliance with care plans for
 2.4 high-cost medical and high-cost psychiatric conditions. Care coordination services must
 2.5 be available through in-home video, telehealth management, and other methods.

2.6 Sec. 2. Minnesota Statutes 2010, section 256B.69, subdivision 6, is amended to read:

2.7 Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for
 2.8 the health care coordination for eligible individuals. Demonstration providers:

2.9 (1) shall authorize and arrange for the provision of all needed health services
 2.10 including but not limited to the full range of services listed in sections 256B.02,
 2.11 subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to
 2.12 enrollees. Notwithstanding section 256B.0621, demonstration providers that provide
 2.13 nursing home and community-based services under this section shall provide relocation
 2.14 service coordination to enrolled persons age 65 and over;

2.15 (2) shall accept the prospective, per capita payment from the commissioner in return
 2.16 for the provision of comprehensive and coordinated health care services for eligible
 2.17 individuals enrolled in the program;

2.18 (3) may contract with other health care and social service practitioners to provide
 2.19 services to enrollees; and

2.20 (4) shall institute recipient grievance procedures according to the method established
 2.21 by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved
 2.22 through this process shall be appealable to the commissioner as provided in subdivision 11.

2.23 (b) Demonstration providers must comply with the standards for claims settlement
 2.24 under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health
 2.25 care and social service practitioners to provide services to enrollees. A demonstration
 2.26 provider must pay a clean claim, as defined in Code of Federal Regulations, title 42,
 2.27 section 447.45(b), within 30 business days of the date of acceptance of the claim.

2.28 (c) A demonstration provider must accept into its medical assistance and
 2.29 MinnesotaCare provider networks any health care or social service provider that agrees
 2.30 to accept payment, quality assurance, and other contract terms that the demonstration
 2.31 provider applies to other similarly situated providers in its provider network.

2.32 **EFFECTIVE DATE.** This section is effective January 1, 2013, and applies to
 2.33 provider contracts that take effect on or after that date.

2.34 Sec. 3. Minnesota Statutes 2010, section 256B.69, subdivision 9, is amended to read:

3.1 Subd. 9. **Reporting.** (a) Each demonstration provider shall submit information as
3.2 required by the commissioner, including data required for assessing client satisfaction,
3.3 quality of care, cost, and utilization of services for purposes of project evaluation. The
3.4 commissioner shall also develop methods of data reporting and collection in order to
3.5 provide aggregate enrollee information on encounters and outcomes to determine access
3.6 and quality assurance. Required information shall be specified before the commissioner
3.7 contracts with a demonstration provider.

3.8 (b) Aggregate nonpersonally identifiable health plan encounter data, aggregate
3.9 spending data for major categories of service as reported to the commissioners of
3.10 health and commerce under section 62D.08, subdivision 3, clause (a), and criteria for
3.11 service authorization and service use are public data that the commissioner shall make
3.12 available and use in public reports. The commissioner shall require each health plan and
3.13 county-based purchasing plan to provide:

3.14 (1) encounter data for each service provided, using standard codes and unit of
3.15 service definitions set by the commissioner, in a form that the commissioner can report by
3.16 age, eligibility groups, and health plan; and

3.17 (2) criteria, written policies, and procedures required to be disclosed under section
3.18 62M.10, subdivision 7, and Code of Federal Regulations, title 42, part 438.210(b)(1), used
3.19 for each type of service for which authorization is required.

3.20 (c) Each demonstration provider shall report to the commissioner on the extent to
3.21 which providers employed by or under contract with the demonstration provider comply
3.22 with the patient-centered decision-making requirements of section 256B.7671 and the
3.23 steps taken by the demonstration provider to encourage compliance.

3.24 Sec. 4. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
3.25 to read:

3.26 Subd. 32. **Initiatives to reduce incidence of low birth weight.** The commissioner
3.27 shall require managed care and county-based purchasing plans, as a condition of contract,
3.28 to implement strategies to reduce the incidence of low birth weight in geographic areas
3.29 identified by the commissioner as having a higher than average incidence of low birth
3.30 weight. The strategies must coordinate health care with social services and the local
3.31 public health system. Each plan shall develop and report to the commissioner outcome
3.32 measures related to reducing the incidence of low birth weight. The commissioner shall
3.33 consider the outcomes reported when considering plan participation in the competitive
3.34 bidding program established under subdivision 33.

4.1 Sec. 5. Minnesota Statutes 2010, section 256B.69, is amended by adding a subdivision
4.2 to read:

4.3 Subd. 33. **Competitive bidding.** (a) For managed care contracts effective on or after
4.4 January 1, 2014, the commissioner shall establish a competitive price bidding program for
4.5 nonelderly, nondisabled adults and children in medical assistance and MinnesotaCare in
4.6 the seven-county metropolitan area. The program must allow a minimum of two managed
4.7 care plans to serve the metropolitan area. Competitive bidding contracts shall be reopened
4.8 and rebid every two calendar years.

4.9 (b) In designing the competitive bid program, the commissioner shall consider, and
4.10 incorporate where appropriate, the procedures and criteria used in the competitive bidding
4.11 pilot authorized under Laws 2011, First Special Session chapter 9, article 6, section 96.

4.12 (c) The commissioner shall require managed care plans to submit data on enrollee
4.13 health outcomes and shall consider this information, along with competitive bid and other
4.14 information, in determining whether to contract with a managed care plan under this
4.15 subdivision. The data submitted must include health outcome measures on reducing the
4.16 incidence of low birth weight established by the managed care plan under subdivision 32.

4.17 Sec. 6. **[256B.7671] PATIENT-CENTERED DECISION MAKING.**

4.18 (a) For purposes of this section, "patient-centered decision-making process" means a
4.19 process that involves directed interaction with the patient to assist the patient in arriving at
4.20 an informed objective health care decision regarding the surgical procedure that is both
4.21 informed and consistent with the patient's preference and values. The interaction may be
4.22 conducted by a health care provider or through the use of electronic decision aids. If
4.23 decision aids are used in the process, the aids must meet the criteria established by the
4.24 International Patients Decision Aids Standards Collaboration or the Cochrane Decision
4.25 Aid Registry.

4.26 (b) Effective January 1, 2013, the commissioner of human services shall require
4.27 active participation in a patient-centered decision-making process before authorization is
4.28 approved or payment reimbursement is provided for any of the following:

4.29 (1) a surgical procedure for abnormal uterine bleeding, benign prostate enlargement,
4.30 chronic back pain, early stage of breast and prostate cancers, gastroesophageal reflux
4.31 disease, hemorrhoids, spinal stenosis, temporomandibular joint dysfunction, ulcerative
4.32 colitis, urinary incontinence, uterine fibroids, or varicose veins; and

4.33 (2) bypass surgery for coronary disease, angioplasty for stable coronary artery
4.34 disease, or total hip replacement.

5.1 (c) A list of the procedures in paragraph (b) shall be published in the State Register
5.2 by October 1, 2012. The list shall be reviewed no less than every two years by the
5.3 commissioner, in consultation with the commissioner of health. The commissioner
5.4 shall hold a public forum and receive public comment prior to any changes to the list in
5.5 paragraph (b). Any changes made shall be published in the State Register.

5.6 (d) Prior to receiving authorization or reimbursement for the procedures identified
5.7 under this section, a health care provider must certify that the patient has participated in a
5.8 patient-centered decision-making process. The format for this certification and the process
5.9 for coordination between providers shall be developed by the Health Services Policy
5.10 Committee under section 256B.0625, subdivision 3c.

5.11 (e) This section does not apply if any of the procedures identified in this section are
5.12 performed under an emergency situation.

5.13 **Sec. 7. DATA ON CLAIMS AND UTILIZATION.**

5.14 The commissioner of human services, in consultation with the legislative committees
5.15 with jurisdiction over health care policy, shall develop and provide to the legislature
5.16 by December 15, 2012, a methodology and any draft legislation necessary to allow for
5.17 the release, upon request, of summary data as defined in Minnesota Statutes, section
5.18 13.02, subdivision 19, on claims and utilization for medical assistance and MinnesotaCare
5.19 enrollees at no charge to the University of Minnesota Medical School, the Mayo Medical
5.20 School, Northwestern Health Sciences University, the Institute for Clinical Systems
5.21 Improvement, and other research institutions to conduct analyses of health care outcomes
5.22 and treatment effectiveness, provided the research institutions do not release private or
5.23 nonpublic data or data for which dissemination is prohibited by law.