State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 3045

03/14/2016 Authored by Zerwas and Anderson, S.,
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to health; modifying provisions for health care quality of care and complaint investigation process; requiring a report; amending Minnesota Statutes 2014, sections 62D.04, subdivision 1; 62Q.72, subdivision 1, by adding a subdivision; 145.64, subdivision 5; proposing coding for new law in Minnesota Statutes, chapter 62D.

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

Section 1. Minnesota Statutes 2014, section 62D.04, subdivision 1, is amended to read:

Subdivision 1. **Application review.** Upon receipt of an application for a certificate of authority, the commissioner of health shall determine whether the applicant for a certificate of authority has:

(a) demonstrated the willingness and potential ability to assure that health care services will be provided in such a manner as to enhance and assure both the availability and accessibility of adequate personnel and facilities;

(b) arrangements for an ongoing evaluation of the quality of health care, including a peer review process;

(c) a procedure to develop, compile, evaluate, and report statistics relating to the cost of its operations, the pattern of utilization of its services, the quality, availability and accessibility of its services, and such other matters as may be reasonably required by regulation of the commissioner of health;

(d) reasonable provisions for emergency and out of area health care services;

(e) demonstrated that it is financially responsible and may reasonably be expected to meet its obligations to enrollees and prospective enrollees. In making this determination, the commissioner of health shall require the amount of initial net worth required in section

62D.042, compliance with the risk-based capital standards under sections 60A.50 to 60A.592, the deposit required in section 62D.041, and in addition shall consider:

(1) the financial soundness of its arrangements for health care services and the proposed schedule of charges used in connection therewith;

(2) arrangements which will guarantee for a reasonable period of time the continued availability or payment of the cost of health care services in the event of discontinuance of the health maintenance organization; and

(3) agreements with providers for the provision of health care services;

(f) demonstrated that it will assume full financial risk on a prospective basis for the provision of comprehensive health maintenance services, including hospital care; provided, however, that the requirement in this paragraph shall not prohibit the following:

(1) a health maintenance organization from obtaining insurance or making other arrangements (i) for the cost of providing to any enrollee comprehensive health maintenance services, the aggregate value of which exceeds $5,000 in any year, (ii) for the cost of providing comprehensive health care services to its members on a nonelective emergency basis, or while they are outside the area served by the organization, or (iii) for not more than 95 percent of the amount by which the health maintenance organization's costs for any of its fiscal years exceed 105 percent of its income for such fiscal years; and

(2) a health maintenance organization from having a provision in a group health maintenance contract allowing an adjustment of premiums paid based upon the actual health services utilization of the enrollees covered under the contract, except that at no time during the life of the contract shall the contract holder fully self-insure the financial risk of health care services delivered under the contract. Risk sharing arrangements shall be subject to the requirements of sections 62D.01 to 62D.30;

(g) demonstrated that it has made provisions for and adopted a conflict of interest policy applicable to all members of the board of directors and the principal officers of the health maintenance organization. The conflict of interest policy shall include the procedures described in section 317A.255, subdivisions 1 and 2. However, the commissioner is not precluded from finding that a particular transaction is an unreasonable expense as described in section 62D.19 even if the directors follow the required procedures; and

(h) otherwise met the requirements of sections 62D.01 to 62D.30.

Sec. 2. **[62D.115] QUALITY OF CARE COMPLAINTS.**

Subdivision 1. **Quality of care complaint.** For purposes of this section, "quality of care complaint" means any grievance regarding an expressed dissatisfaction with services rendered to enrollees with potential or actual adverse outcomes that impact delivery of

care to the enrollee. Quality of care complaints may include, but are not limited to, provider and staff competence, appropriateness, communications, behavior, or facility and environmental considerations, and other factors that could impact the quality of health care services.

Subd. 2. **Quality of care complaint investigation.** (a) Each health maintenance organization shall develop and implement policies and procedures for a quality of care complaint investigation process that meets the requirements of this section. The health maintenance organization must have a written policy and procedure for receipt, investigation, and follow-up of quality of care complaints, including the requirements in paragraphs (b) to (g).

(b) A definition of quality of care complaint to include such concerns as identified in subdivision 1.

(c) A description of levels of severity including:

(i) classifications of complaints that warrant peer protection confidentiality as defined by the commissioner of health; and

(ii) investigation procedures for each level of severity.

(d) Every complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization. Documentation must show every allegation was addressed.

(e) Conclusions must be supported with evidence that may include an associated corrective action plan implemented and documented and a formal response from a provider to the health plan. The record of investigation must include all related documents, correspondence, summaries, discussions, consultations, and conferences held.

(f) A medical director review will be conducted when there is potential for patient harm.

(g) Quality of care complaints must be tracked and trended for review according to provider and type of quality of care issue: behavior, facility, environmental, and technical competence.

Subd. 3. **Reporting.** Quality of care complaints must be reported as outlined under section 62Q.72, subdivision 3.

Sec. 3. Minnesota Statutes 2014, section 62Q.72, subdivision 1, is amended to read:

Subdivision 1. **Record keeping.** Each health plan company shall maintain records of all enrollee complaints, including quality of care complaints, and their resolutions. These records shall be retained for five years and shall be made available to the appropriate

commissioner upon request. An insurance company licensed under chapter 60A may instead comply with section 72A.20, subdivision 30.

Sec. 4. Minnesota Statutes 2014, section 62Q.72, is amended by adding a subdivision to read:

Subd. 3. **Complaint reporting.** Each health maintenance organization shall submit to the commissioner of health, as part of the company's annual filing, data on the number of complaints and the category as defined by the commissioner of health. Categories shall include, but are not limited to, access, communication and behavior, health plan administration, facilities and environment, coordination of care, and technical competence and appropriateness. The commissioner shall define complaint categories by January 1, 2017.

Sec. 5. Minnesota Statutes 2014, section 145.64, subdivision 5, is amended to read:

Subd. 5. **Commissioner of health.** Nothing in this section shall be construed to prohibit or restrict the right of the commissioner of health to: (1) access the ~~original~~ information, documents, or records acquired by a review organization as permitted by law; and (2) receive documentation of all discussions, consultations, conferences, the date or dates of each interaction, the outcome of each interaction, and the final determination.