A bill for an act

relating to human services; requiring certain medical assistance enrollees and all MinnesotaCare enrollees to receive basic services through an enrolled provider network; providing major medical coverage to these enrollees; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.0758] ENROLLED PROVIDER NETWORKS; MAJOR MEDICAL COVERAGE.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Demonstration provider" has the meaning provided in section 256B.69, subdivision 2.

(c) "Enrolled provider network" means a health care provider or group of health care providers that are accountable through a contract with the commissioner for: (1) the quality and coordination of care provided under subdivision 3 to qualified enrollees; and (2) managing the cost of providing this care.

(d) "Health plan company" has the meaning specified in section 62Q.01, subdivision 4.

(e) "Metropolitan statistical area" means a metropolitan area containing a core urban area of 50,000 or more population, consisting of one or more counties including the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration with the urban core.

(f) "Qualified enrollee" means an individual who is enrolled in medical assistance under a families and children eligibility category, or as an adult without children under

section 256B.055, subdivision 15, or enrolled in the MinnesotaCare program under chapter 256L.

Subd. 2. **Establishment of reformed health care delivery system.** (a) The commissioner shall implement, by January 1, 2012, or upon federal approval, whichever is later, a reformed health care delivery system for qualified medical assistance and MinnesotaCare enrollees that delivers basic health care services through enrolled provider networks in metropolitan statistical areas (MSAs), and supplements this coverage with a major medical policy. Health care providers outside of a metropolitan statistical area may serve as an enrolled provider network and receive total cost of care payments under subdivision 3, or may choose to receive payments on a fee-for-service basis only.

(b) No later than July 1, 2012, or upon federal approval, the commissioner shall discontinue contracts with managed care under sections 256B.69 and 256L.12 for the provision of services to qualified enrollees.

Subd. 3. **Provision of basic care services through enrolled provider networks.** (a) The commissioner shall enter into contracts with enrolled provider networks in metropolitan statistical areas, and may enter into contracts with enrolled provider networks outside of a metropolitan statistical area, to provide qualified enrollees with the basic care services specified in paragraph (b), in return for receiving a per-enrollee, concurrently risk-adjusted, total cost of care payment.

(b) Enrolled provider networks under contract with the commissioner shall provide, contract for, and coordinate the following basic care services:

(1) preventive services;

(2) inpatient hospital services, and physician and other health care professional services associated with an inpatient hospital stay, subject to an annual limit of $.....;

(3) outpatient hospital services;

(4) freestanding ambulatory surgical center services;

(5) outpatient physician and clinic visits;

(6) lab, x-ray, and diagnostic services;

(7) diabetic care services;

(8) mental health care;

(9) vision care, with eyeglasses covered as provided under subdivision 8;

(10) prescription drugs, subject to an annual limit of $.....;

(11) medication therapy management;

(12) emergency room care;

(13) immunizations and vaccines;

(14) rehabilitative therapy;

(15) urgent care;

(16) home care; and

(17) hospice care.

(c) An enrolled provider network may provide qualified enrollees with services that are in addition to those listed in paragraph (b).

(d) No enrollee cost-sharing shall be applied to the services listed in paragraph (b).

(e) An enrolled provider network must coordinate the services provided under paragraph (b) with any major medical services that an enrollee receives under subdivision 6.

(f) The commissioner shall, by competitive bid, award a contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services by enrolled provider networks and administer fee-for-service payments to providers who are not part of an enrolled provider network. The entity awarded the contract must:

(1) collect data on the utilization and cost of health care services provided by each enrolled provider network compared to providers who are not part of an enrolled provider network, and on administrative and other costs incurred by enrolled provider network compared to providers who are not part of an enrolled provider network, and make this information available to enrolled provider networks and the commissioner;

(2) assist enrolled provider networks and the commissioner in identifying high-cost enrollees;

(3) track expenditures for services for which there are annual dollar limits, and notify enrolled provider networks and the commissioner when an enrollee has reached a service dollar limit;

(4) evaluate the cost and quality of services provided by enrolled provider networks in comparison to providers who are not part of an enrolled provider network, and report this information to enrolled provider networks and the commissioner; and

(5) ensure access for enrollees to available enrolled provider networks and fee-for-service providers. The administrator shall report to the commissioner any access concerns which may arise under this reformed health care delivery system.

Data reported to the third-party administrator and the commissioner under this paragraph are public data as defined in section 13.02, except that data on individuals are classified as private data.

Subd. 4. **Enrollee selection of enrolled provider network.** (a) A qualified enrollee within a metropolitan statistical area (MSA) must select an enrolled provider network in order to receive services covered under this section. The commissioner shall assign an

enrollee to a enrolled provider network based on greatest percentage of services recently provided to that enrollee, or proximity, if the enrollee does not make a choice. An enrollee must agree to receive all nonemergency covered services through the enrolled provider network, except for major medical services covered under subdivision 6 and services provided on a fee-for-service basis under subdivision 8.

(b) An enrollee covered through an enrolled provider network and major medical coverage has right to appeal to the commissioner according to section 256.045.

Subd. 5. **Non-MSA providers.** (a) A provider located outside of a metropolitan statistical area shall be paid on a fee-for-service basis for covered services provided to qualified enrollees, unless the provider is part of an enrolled provider network and voluntarily chooses to participate under this section. Providers located outside of a metropolitan statistical area may participate in county-based purchasing options in collaboration with their county or a group of counties in the region.

(b) The commissioner of human services may consider other payment mechanisms with providers that allow the commissioner to achieve cost-savings, including, but not limited to, gain sharing arrangements with a county or group of providers, baskets of care, and other payment mechanisms the commissioner determines would improve the quality and efficiency of service delivery to qualified enrollees residing outside of a metropolitan statistical area.

Subd. 6. **Major medical coverage.** (a) The commissioner shall, by competitive bid, award a contract to a health plan company to provide to qualified enrollees statewide the major medical policy specified in paragraph (b).

(b) The major medical policy must cover the following:

(1) inpatient hospital and associated physician and health professional costs that in the aggregate exceed $..... per year;

(2) physician and other health care professional costs not associated with an inpatient hospital stay, that in the aggregate exceed $..... per year; and

(3) prescription drugs costs, that exceed $..... per year.

(c) The major medical policy must require providers who are not part of an enrolled provider network who provide services to a qualified enrollee to coordinate these services with those provided by the enrollee's enrolled provider network. The policy must also provide an appeals mechanism for qualified enrollees.

(d) No enrollee cost-sharing shall apply to coverage under the major medical policy.

(e) The commissioner may require an enrolled provider network to enter into a risk/gain-sharing agreement, under which the enrolled provider network shall be

financially responsible for a portion of the risk-adjusted major medical costs incurred by qualified enrollees.

Subd. 7. **Premiums.** (a) MinnesotaCare enrollees receiving benefits under this section must pay premiums as provided in section 256L.15.

(b) Medical assistance enrollees receiving benefits under this section shall pay premiums based on the MinnesotaCare sliding premium scale, as established under section 256L.15.

Subd. 8. **Services provided through fee-for-service.** The following services provided to qualified enrollees shall be reimbursed on a fee-for-service basis by the entity awarded the third-party administrator contract under subdivision 3:

(1) emergency and nonemergency medical transportation services;

(2) alcohol and drug treatment;

(3) chiropractic care;

(4) dental care, with dental services provided to nonpregnant adults subject to an annual limit of $.....;

(5) eyeglasses, subject to an annual limit of $.....;

(6) hearing aids;

(7) interpreter services;

(8) medical equipment and supplies;

(9) prescriptions; and

(10) services provided in nursing facilities, intermediate facilities for persons with development disabilities, and other long-term care settings.

Subd. 9. **Other services for children.** The medical assistance and MinnesotaCare programs shall continue to cover, on a fee-for-service basis, health care services identified as medically necessary for children as part of a child and teen checkup visit, if these services are not covered under subdivision 3, 6, or 8.

Subd. 10. **Retaliation prohibited.** The commissioners of human services, health, and commerce, as a condition of licensure or contract, shall prohibit health plan companies and demonstration providers from retaliating against enrolled provider networks for providing services under this section. For purposes of this prohibition, "retaliation" includes, but is not limited to, reducing payment rates in other books of business, arranging for network exclusions, or otherwise adversely changing contract terms.

Subd. 11. **Federal approval.** The commissioner shall seek any necessary federal waivers and approvals necessary to implement this section.