SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 1696

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DATE	D-PG	OFFICIAL STATUS
03/12/2015	780	Introduction and first reading Referred to Commerce

A bill for an act

relating to commerce; establishing continued care at home contracts; requiring providers to prove financial responsibility to the commissioner of commerce; amending Minnesota Statutes 2014, section 609.232, subdivision 11; proposing coding for new law as Minnesota Statutes, chapter 80H.

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

Section 1. **[80H.01] CONTINUING CARE AT HOME PROGRAM; PURPOSE AND GOALS.**

The legislature finds that the following objectives may be further enhanced through the establishment and promotion of continuing care at home providers:

(1) enabling persons to age in place in their own homes as independently and as long as possible;

(2) enhancing private funding of long-term support services;

(3) enabling persons to plan for their future potential need for long-term care and support services;

(4) reducing or containing medical assistance expenditures; and

(5) reducing or forestalling placements at nursing facilities and assisted living facilities.

Sec. 2. **[80H.02] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given to them.

Subd. 2. **Affiliated with.** "Affiliated with" means a common ownership or control with a licensed health care provider.

Subd. 3. **Ancillary services.** (a) "Ancillary services" may include care coordination, care management, wellness programs, health assessments, health information analysis, necessary referrals to independent providers, home safety evaluations, homemaker services, personal emergency response systems, smart-home technology services, physical accessibility enhancements, and chronic disease management.

(b) Ancillary services are covered by the premiums charged under the CCaH plan and may not be billed separately. Ancillary services must commence upon the effective date of the participant's CCaH plan.

Subd. 4. **Care coordination.** "Care coordination" means developing and implementing a plan of care to address the participant's needs throughout the participant's enrollment in the CCaH plan. This includes, but is not limited to, assisting a participant to access benefits available through third party payors including Medicare, medical assistance, waivered services, or private insurance plans, and to coordinate those benefits with the core and ancillary services provided under the CCaH plan.

Subd. 5. **Common ownership or control.** "Common ownership or control" means a CCaH provider and licensed health provider are:

(1) owned or operated by the same person, corporation, limited liability company, or partnership;

(2) subsidiaries of a common parent corporate organization;

(3) operated under management agreements with a single managing entity;

(4) governed by directors, officers, partners, or members appointed by a single organization; or

(5) directly related by other operation of laws.

Subd. 6. **Continuing care at home plan.** "Continuing care at home plan" or "CCaH plan" means an enrollment arrangement between a participant and a CCaH provider wherein the CCaH provider provides long-term care and support core services and ancillary services in accordance with this chapter once a participant becomes eligible to claim and receive services, effective up to the maximum benefit amount purchased by a participant. Enrollment in a CCaH plan shall be:

(1) pursuant to a CCaH contract between the CCaH provider and a participant that meets the terms and conditions of section 80H.03;

(2) provided in consideration of a participant's payment of established premiums to the CCaH provider. Premiums shall be charged by the CCaH provider on a monthly basis, but a participant may elect to pay the CCaH plan premium either monthly, annually, or quarterly, so long as the participant has selected the participant's payment option in the CCaH contract, or any subsequent amendment thereto; and

(3) available to qualified applicants between the ages of 50 and 80, whose further qualifications for eligibility under the CCaH plan are subject to independent underwriting and evaluations of the applicant's health status based on information produced by the applicant during the application process. The applicant may be required to provide a written application disclosing relevant personal data including medical and familial health history and medical records from the applicant's physicians or other health providers. The application process may include personal interviews, mental and physical health examinations, or clinical nursing assessments. The CCaH provider and any designee must comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations, and all applicable requirements with respect to all protected health information obtained during the application process, whether or not the applicant enrolls in the CCaH plan.

Subd. 7. **Continuing care at home provider.** "Continuing care at home provider" or "CCaH provider" means a corporation, limited liability company, or partnership that meets the financial responsibility requirements of section 80H.04, subdivision 2, offers to provide core services to enrolled participants under a CCaH plan, and is affiliated with two or more licensed health care providers.

Subd. 8. **Core services.** (a) "Core services" which may be offered in a CCaH plan are long-term care and support services defined under sections 144A.02, 144A.46, 144A.75 to 144A.755, 245A.01 to 245A.16, and chapters 144D and 245D. Core services do not replace any benefits that may be otherwise available to a participant from third-party payors, including, but not limited to, Medicare, medical assistance, waivered services, or private insurance, and are offered in addition to and separate from those benefits. Except as provided in paragraph (c), a core service available under a participant's CCaH plan shall only be provided through the licensed health care providers affiliated with the CCaH provider.

(b) Core services are covered by the premiums charged under the CCaH plan and may not be billed separately. Core services must commence at the end of the elimination period.

(c) If offered in good faith for the participant's benefit and if reasonable and necessary to meet the participant's need for core services, the CCaH provider may elect to provide, at its sole option, a core service through a licensed health care provider not affiliated with the CCaH provider. The CCaH provider must enter into a participating provider contract with the unaffiliated health care provider. The unaffiliated licensed health care provider shall not charge the participant for core service. The participating provider contract shall obligate the CCaH provider to pay for the participant's core services at a negotiated payment rate mutually acceptable to the CCaH provider and the

unaffiliated licensed health care provider. The CCaH provider shall have and maintain access to the participant's health data for purposes of coordinating the participant's care. The CCaH provider shall not engage unaffiliated licensed health care providers solely for the CCaH provider's convenience. Engaging an unaffiliated licensed health care provider shall not be grounds for a premium increase.

Subd. 9. **Elimination period.** "Elimination period" means a number of days, weeks, or months specified in the CCaH plan and commences at the beginning of each period of the participant's confirmed need. Core services are provided upon the conclusion of the elimination period. Ancillary services continue throughout the elimination period, and the care coordinator shall assist the participant in finding necessary home health or long-term care services during the elimination period either at the participant's expense, or as covered by Medicare, medical assistance, or private insurance.

Subd. 10. **Home.** "Home" means the participant's place of residence, including independent senior living apartment buildings, regardless of ownership.

Subd. 11. **Licensed health care provider.** "Licensed health care provider" means:

(1) a nursing home licensed to serve adults under section 144A.02;

(2) a home care provider licensed under section 144A.46;

(3) a housing with services site registered under chapter 144D;

(4) a hospice provider licensed under sections 144A.75 to 144A.755;

(5) an organization authorized to provide personal care assistance or basic support services licensed under chapter 245D; or

(6) a residential or nonresidential facility required to be licensed to service adults under sections 245A.01 to 245A.16.

Subd. 12. **Maximum benefit amount.** "Maximum benefit amount" means the maximum dollar amount established by the CCaH plan. The CCaH provider will assure or provide core and ancillary services up to the maximum benefit amount upon the participant's initial and continued need and eligibility to claim and receive such services. Participants shall select daily and maximum total benefit amounts upon enrollment.

Subd. 13. **Participant.** (a) "Participant" means an individual who has been accepted for enrollment in a CCaH plan and who enters into an enrollment contract with a CCaH provider and who agrees to pay the premiums from the participant's private resources.

(b) A participant may also include any individual, including a medical assistance program or home and community-based waiver recipient, who has a third-party payor, such as a supportive family member, enter into the CCaH plan to be directly responsible for paying the premium on the participant's behalf. The amount paid by a third-party payor

shall not be included in the participant's income for purposes of evaluating the participant's eligibility for any medical assistance or waiver program.

Subd. 14. **Premium.** "Premium" means the amount charged by the CCaH provider to maintain the participant's enrollment in the CCaH plan. The premium need not be guaranteed and may be adjusted by the CCaH provider in accordance with the terms of the CCaH plan. The premium charged shall cover all payments due to the CCaH provider for core and ancillary services.

Subd. 15. **Private resources.** "Private resources" means the liquid financial assets of the participant or any third-party payor who agrees, in writing, to pay the premiums and charges for core, ancillary, or supplemental services. A CCaH provider shall not take a reverse mortgage or other equitable interest in a home or other asset owned by the participant as payment for the premium during the participant's enrollment in the CCaH plan.

Subd. 16. **Supplemental services.** "Supplemental services" are arranged, reviewed, and recommended by the CCaH provider at the request of the participant through independent vendors and are charged to the participant separately from the premium. Supplemental services shall not include core or ancillary services, but may include arranging contracts with qualified vendors to provide necessary repairs, improvements, or accessibility upgrades to a participant's home or furnishings, or routine home maintenance needs. Supplemental services, including the nature, scope, and estimated cost, must be offered in advance for the participant's prior authorization.

Sec. 3. **[80H.03] CONTINUING CARE AT HOME CONTRACT.**

Subdivision 1. **Continuing care at home contract.** (a) A continuing care at home contract provided under a CCaH plan between a CCaH provider and a participant shall describe:

(1) the maximum benefit amount and any daily benefit limit;

(2) the premium;

(3) the benefits provided, including:

(i) the core services selected by the participant;

(ii) the ancillary services selected by the participant;

(iii) the level of initial and continued need necessary to trigger a participant's access to core services, including, if applicable, the number of daily living activities that a participant is unable to perform;

(iv) the level of a participant's improvement required to cease or modify commenced core services safely; and

(v) the geographical limits on the CCaH provider's services area;

(4) the elimination period;

(5) the notification required for premium increase, which shall not be less than 30 days;

(6) the option of a fixed premium for a period not greater than five years;

(7) the option of a premium discount of up to 20 percent for cohabitants enrolling contemporaneously as participants;

(8) the application fee, which shall not exceed $100, and which shall be fully refunded to the applicant if the applicant does not pass underwriting or if the applicant elects not to enroll in a CCaH plan;

(9) termination requirements for both the participant and the CCaH provider as provided in subdivision 3;

(10) a description of supplemental services available through the CCaH provider for payment of an additional charge;

(11) the terms by which a CCaH provider may offer, and a participant may accept:

(i) additional core services or ancillary services;

(ii) inflation protection for the daily benefit limit; and

(iii) a survivorship provision that transfers a participant's unused maximum benefit amount to a surviving spouse who is also a participant;

(12) that the CCaH provider is authorized to require the participant to use additional core services as provided in subdivision 2; and

(13) a grievance procedure enabling the participant to submit written grievances regarding the provision of core or ancillary services as described in subdivision 4.

(b) The contract must also include provisions explaining what must occur if a participant chooses a nonplan participating provider within the plan's designated service area. If a patient makes this choice, the participant shall agree to pay for the services and submit documentation to the CCaH provider on the delivery of care and payment for the care. The CCaH provider must then reimburse the participant for the lesser of the amount paid by the participant for the care provided or the CCaH provider's average cost of care provided by a plan participating provider for any such services up to the maximum daily benefit in the participant's agreement.

Subd. 2. **CCaH provider's authority to require additional core services.** (a) A CCaH provider is authorized to require the participant to use additional core services that are available under the maximum benefit amount, including, but not limited to, transferring the participant to a licensed assisted living or skilled nursing facility arranged by the CCaH provider, in order to prevent either:

(1) the participant's self-neglect as defined by section 626.5572, subdivision 17, paragraph (b); or

(2) the participant from being unsafe to others in the community or from harming any other vulnerable adult as defined by section 626.5572, subdivision 21.

(b) The CCaH provider shall consult with and consider recommendations of the participant's primary care physician unless the participant refuses to cooperate with the physician. The CCaH provider shall evaluate the participant's number of activities of daily living dependencies and the supports necessary to remain living at home before requiring additional services.

Subd. 3. **Contract termination procedures.** (a) A participant may terminate a contract with a CCaH provider with 30 days' written notice to the CCaH provider. A participant may terminate the contract for any reason, including, but not limited to, the participant's dissatisfaction with care recommendations, premium increases, or because the participant is relocating outside the service areas covered by the CCaH provider.

(b) A CCaH provider may terminate a contract with a participant only for good cause. Good cause shall be limited to any of the following:

(1) nonpayment of premiums;

(2) a participant's continued and repeated refusal to participate in medical examinations or other evaluations arranged by the CCaH provider's care coordinator, thereby causing reasonable concern that the participant may not be claiming or receiving necessary core services;

(3) the participant's refusal to accept the additional core services identified by the CCaH provider pursuant to subdivision 2;

(4) the participant's continued and repeated noncompliance with the care recommendations and directives of the CCaH provider or licensed health professional engaged by the CCaH provider;

(5) a material misrepresentation made intentionally or recklessly by the participant or the participant's representative during the application process for enrollment or the failure to produce related materials and information which, if provided in a timely manner, would have resulted in either the applicant's rejection for enrollment or in a material increase in the cost of the offered premium; or

(6) the participant's material breach of the terms and conditions under the contract.

(c) A CCaH provider must give a participant notice of the grounds for termination under paragraph (b) and give the participant a reasonable opportunity to cure, not to exceed 30 days. The opportunity to cure shall not prevent the CCaH provider from immediately

notifying the lead investigative agency if the CCaH provider has reason to believe the participant is subject to self-neglect under section 626.5572, subdivision 17, paragraph (b).

(d) The contract between a CCaH provider and a participant and the participant's enrollment in a CCaH plan terminates upon the exhaustion of the maximum benefit amount or the death of the participant, whichever is earlier.

(e) Upon proper notice of termination under this subdivision or upon the death of the participant, the CCaH provider shall refund, pro rata, any prepaid premium to the participant or the participant's estate.

Subd. 4. **Grievances.** Written grievances may be filed by a participant to a CCaH provider regarding any service or concern regarding the participant's agreement with a CCaH provider. Grievances shall be filed with and acted upon by the CCaH provider's director of care coordination. If unresolved within ten business days, the grievance shall be forwarded to the executive director of the CCaH provider for final review and action. Nothing in this subdivision alters the participant's right to report suspected maltreatment under section 626.557 or limits the participant's rights under section 144.651, if applicable.

Sec. 4. **[80H.04] CONTINUING CARE AT HOME PROVIDER QUALIFICATIONS.**

Subdivision 1. **Provision of services.** (a) A CCaH provider may provide core services only through affiliated or unaffiliated licensed health care providers, as established in section 80H.02, subdivision 8.

(b) A CCaH provider may arrange for supplemental services and may provide nonhealth care goods and services through vendors on a transactional basis for fees in addition to premiums paid.

(c) An employee of a CCaH provider who has direct contact with a participant is subject to a background study under chapter 245C and the CCaH provider shall submit that employee for a background study, unless that employee has already obtained a background study clearance as a result of a submission by a licensed health care provider affiliated with the CCaH provider.

(d) Care coordination provided under ancillary services may either be performed by licensed professionals, including registered nurses or licensed clinical social workers, or at a licensed professional's direction by unlicensed staff. Unlicensed staff coordinating care under supervision must have a college degree and must demonstrate to the CCaH provider's satisfaction that the unlicensed person has completed training in case management and coordination in long-term care and support.

Subd. 2. **Proof of financial responsibility.** (a) A CCaH provider shall either:

(1) annually file with the commissioner of commerce a performance bond or equivalent proof of financial responsibility in the amount equal to the total of all participant premiums collected, as adjusted annually for usage, refunds, or subsequent entrance fee collection; or

(2) if the CCaH provider is affiliated with an organization with assets greater than $25,000,000, the CCaH provider may file with the commissioner a financial guarantee executed by the affiliated organization that guarantees payment of an amount equivalent to the refund of any unused portion of the premium due to a participant for any reason.

(b) On an annual basis, a CCaH provider shall make available to participants reviews conducted by independent actuaries and audits by its independent certified public accounts.

Subd. 3. **Disclosure statement.** A CCaH provider shall annually file a disclosure statement with the commissioner that identifies the members or owners of the CCaH and includes a template of its CCaH contract and a list of participating health care providers, whether affiliated or unaffiliated.

Subd. 4. **Confidentiality.** A CCaH provider must comply with the Health Insurance Portability and Accountability Act of 1996 and its implementing regulations and all applicable requirements with respect to all protected health information obtained, including the Minnesota Health Records Act.

Sec. 5. **[80H.05] CONTINUING CARE AT HOME EXEMPTIONS.**

CCaH plans and contracts under this chapter are not Medicare gap supplemental insurance policies and the CCaH services defined and offered are separate from, and in addition to, any insurance or Medicare coverage for which a participant may be eligible. CCaH plans offered under this chapter are not contracts of insurance and CCaH programs are exempt from the general insurance powers of chapter 60A and the laws governing health maintenance organizations and managed care organizations. CCaH providers are not continuing care facilities under chapter 80D.

Sec. 6. **[80H.06] MANDATED REPORTERS.**

Employees of a CCaH provider who have direct contact with participants are mandated reporters under section 626.5572, subdivision 16. When conducting maltreatment investigations under section 626.557, subdivision 9, the lead agency for the licensed health care provider may review and assess the responsibility of a CCaH provider for substantiated maltreatment under section 626.557, subdivision 9c.

Sec. 7. Minnesota Statutes 2014, section 609.232, subdivision 11, is amended to read:

Subd. 11. **Vulnerable adult.** "Vulnerable adult" means any person 18 years of age or older who:

(1) is a resident inpatient of a facility;

(2) receives services at or from a facility required to be licensed to serve adults under sections 245A.01 to 245A.15, except that a person receiving outpatient services for treatment of chemical dependency or mental illness, or one who is committed as a sexual psychopathic personality or as a sexually dangerous person under chapter 253B, is not considered a vulnerable adult unless the person meets the requirements of clause (4);

(3) receives services from a home care provider required to be licensed under section 144A.46~~; or~~, from a person or organization that exclusively offers, provides, or arranges for personal care assistance services under the medical assistance program as authorized under sections 256B.0625, subdivision 19a, 256B.0651 to 256B.0654, and 256B.0659, or from a continuing care at home provider as established under chapter 80H; or

(4) regardless of residence or whether any type of service is received, possesses a physical or mental infirmity or other physical, mental, or emotional dysfunction:

(i) that impairs the individual's ability to provide adequately for the individual's own care without assistance, including the provision of food, shelter, clothing, health care, or supervision; and

(ii) because of the dysfunction or infirmity and the need for assistance, the individual has an impaired ability to protect the individual from maltreatment.