# SENATE
## STATE OF MINNESOTA
## EIGHTY-SEVENTH LEGISLATURE

# S.F. No. 1054

(SENATE AUTHORS: MARTY, Torres Ray, Goodwin and Kubly)

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 03/28/2011 | 770 | Introduction and first reading<br>Referred to Health and Human Services |
| 04/04/2011 | 1157 | Author added Kubly |

A bill for an act

relating to accountability and quality in public health care programs; requiring state contracting directly with health care providers instead of insurance plans; proposing coding for new law in Minnesota Statutes, chapter 256.

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

Section 1. **[256.9631] MEDICAL ASSISTANCE AND MINNESOTACARE REFORM.**

Subdivision 1. **Purpose; intent.** (a) To provide coverage under medical assistance and MinnesotaCare, Minnesota has large contracts totaling over $3,000,000,000 per year in state funds. The state began contracting these programs out in 1983 as a pilot project with the hope of saving money. However, the pilot project was never truly evaluated and no state agency has conducted an audit of these contracts for quality and cost. Under current practice, the state covers all expenses that the health plans incur whether justified or not.

(b) At a time of state financial troubles, rather than attempt to repair these dysfunctional contracts, the state can reduce costs and improve care by contracting directly with medical providers and paying primary care clinics to provide case management to patients.

Subd. 2. **HMO contracts.** The commissioner of human services shall not renew the state's contracts with HMOs providing services to enrollees in the medical assistance and MinnesotaCare programs, except for Minnesota seniors health options (MSHO) and special needs basic care (SNBC). To deal with the complexity of interaction between Medicare and medical assistance, the commissioner shall continue contracting for health care for MSHO and SNBC. The commissioner shall continue to contract with counties

providing care through county-based purchasing systems. For all other enrollees, the commissioner shall contract directly with health care providers to deliver covered services.

Subd. 3. **Scope.** The commissioner shall contract directly with health care providers for current and future eligible medical assistance and MinnesotaCare enrollees in order to achieve better health outcomes, track health care expenditures, and reduce the cost of health care for the state.

Subd. 4. **Case management.** (a) The commissioner shall use the primary care case management (PCCM) model for coordinating services for enrollees who choose a primary care provider to act as the enrollee's case manager. Primary care physicians, clinics, nurses, and other qualified medical professionals may provide primary care case management.

(b) Providers shall bill the state directly for the services they provide. Primary care providers who offer PCCM shall also receive a flat per-member per-month fee. The commissioner shall determine fees for the following groups:

(1) children;

(2) adults; and

(3) the elderly.

The commissioner shall set a higher PCCM fee based on the level of medical and social complexity for patients with chronic or complex conditions or disabilities.

(c) The primary care provider (PCP) shall provide overall oversight of the enrollee's health and coordinate with any other case manager of the enrollee as well as ensure 24-hour access to health care, emergency treatment, and referrals.

(d) The commissioner shall collaborate with community health clinics and social service providers through planning and financing to provide outreach, medical care, and case management services in the community for patients who, because of homelessness or other circumstances, are unlikely to obtain needed care.

(e) The commissioner shall collaborate with medical and social service providers through planning and financing to reduce hospital readmissions by providing discharge planning and services, including medical respite and transitional care for patients leaving medical facilities and mental health and chemical dependency treatment programs.

Subd. 5. **Duties.** (a) For enrollees, the commissioner shall:

(1) maintain a hotline and Web site to assist enrollees in locating providers;

(2) provide a nurse consultation helpline 24 hours per day, seven days a week; and

(3) contact enrollees based on claims data who have not had preventive visits and help them select a PCP.

(b) For the state fiscal management, the commissioner shall:

(1) track utilization rates in all levels of service; and

(2) track health care targets which include:

(i) improved health outcomes for enrollees;

(ii) reduction in avoidable costs, unnecessary emergency room visits, and inpatient utilization;

(iii) improved care coordination;

(iv) improved patient self-management knowledge and treatment of chronic disease; and

(v) improved implementation of evidence-based clinical practice guidelines.

(c) For providers, the commissioner shall:

(1) review provider reimbursement rates to ensure reasonable and fair compensation;

(2) ensure that providers are reimbursed on a timely basis; and

(3) collaborate with providers to explore means of improving health care quality and reducing costs.