SENATE
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S.F. No. 3081

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03/23/2016	5240	Author added Sheran
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A bill for an act

relating to health; modifying provisions for health care quality of care and complaint investigation process; requiring the commissioner of health to develop a medically necessary care definition; amending Minnesota Statutes 2014, sections 62D.04, subdivision 1; 62D.08, subdivision 3; 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. Minnesota Statutes 2014, section 62D.08, subdivision 3, is amended to read:

Subd. 3. **Report requirements.** Such report shall be on forms prescribed by the commissioner of health, and shall include:

(a) a financial statement of the organization, including its balance sheet and receipts and disbursements for the preceding year certified by an independent certified public accountant, reflecting at least (1) all prepayment and other payments received for health care services rendered, (2) expenditures to all providers, by classes or groups of providers, and insurance companies or nonprofit health service plan corporations engaged to fulfill obligations arising out of the health maintenance contract, (3) expenditures for capital improvements, or additions thereto, including but not limited to construction, renovation or purchase of facilities and capital equipment, and (4) a supplementary statement of assets, liabilities, premium revenue, and expenditures for risk sharing business under section 62D.04, subdivision 1, on forms prescribed by the commissioner;

(b) the number of new enrollees enrolled during the year, the number of group enrollees and the number of individual enrollees as of the end of the year and the number of enrollees terminated during the year;

(c) a summary of information compiled pursuant to section 62D.04, subdivision 1, clause (c), in such form as may be required by the commissioner of health;

(d) a report of the names and addresses of all persons set forth in section 62D.03, subdivision 4, clause (c), who were associated with the health maintenance organization or the major participating entity during the preceding year, and the amount of wages, expense reimbursements, or other payments to such individuals for services to the health maintenance organization or the major participating entity, as those services relate to the health maintenance organization, including a full disclosure of all financial arrangements during the preceding year required to be disclosed pursuant to section 62D.03, subdivision 4, clause (d);

(e) a separate report addressing health maintenance contracts sold to individuals covered by Medicare, title XVIII of the Social Security Act, as amended, including the information required under section 62D.30, subdivision 6; ~~and~~

(f) data on the number of complaints received and the category of each complaint as defined by the commissioner. The categories must 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 must define complaint categories to be used by each health maintenance organization by July 1, 2017, and the categories must be used by each health maintenance organization beginning calendar year 2018; and

~~(f)~~ (g) such other information relating to the performance of the health maintenance organization as is reasonably necessary to enable the commissioner of health to carry out the duties under sections 62D.01 to 62D.30.

Sec. 3. **[62D.115] QUALITY OF CARE COMPLAINTS.**

Subdivision 1. **Quality of care complaint.** For purposes of this section, "quality of care complaint" means an expressed dissatisfaction regarding health care services resulting in potential or actual harm to an enrollee. Quality of care complaints may include, but are not limited to, concerns related to provider and staff competence, clinical appropriateness of services, communications, behavior, facility and environmental considerations, or other factors that could impact the quality of health care services.

Subd. 2. **Quality of care complaint investigation.** Each health maintenance organization shall develop and implement policies and procedures for the receipt, investigation, and resolution of quality of care complaints. The policy and procedures must be in writing and must meet the requirements in paragraphs (a) to (g).

(a) A health maintenance organization's definition for quality of care complaints must include the concerns identified in subdivision 1.

(b) A health maintenance organization must classify each quality of care complaint received by severity level as defined by the commissioner and must have investigation procedures for each level of severity.

(c) Any complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization and the health maintenance organization must document the investigation process, including documentation that the complaint was received and investigated, and that each allegation was addressed. The investigation record must include all related documents, correspondence, summaries, discussions, consultations, and conferences held in relation to the investigation of the quality of care complaint in accordance with subdivision 4.

(d) The resolution of a complaint must be supported by evidence and may include a corrective action plan or a formal response from a provider to the health maintenance organization if a formal response was submitted to the health maintenance organization.

(e) Medical director review shall be conducted as part of the investigation process when there is potential for patient harm.

(f) Each quality of care complaint received by a health maintenance organization must be tracked and trended by the health maintenance organization according to provider type and the following type of quality of care issue: behavior, facility, environmental, or technical competence.

(g) The commissioner shall define the quality of care complaints that are subject to peer protection confidentiality and the definition of the severity levels by July 1, 2017.

Subd. 3. **Reporting.** (a) Quality of care complaints must be reported as part of the requirements under section 62D.08, subdivision 3.

(b) All quality of care complaints received by a health maintenance organization that meet the highest level of severity as defined by the commissioner under subdivision 2 must be reported to the commissioner within ten calendar days of receipt of the complaint. The commissioner shall investigate each quality of care complaint received under this paragraph and may contract with experts in health care or medical practice to assist with the investigation.

(c) The commissioner shall forward any quality of care complaint received by a health maintenance organization under this subdivision or received directly from an enrollee of a health maintenance organization that involves the delivery of health care services by a health care provider or facility to the relevant health-related licensing board or state agency for further investigation. Prior to forwarding a complaint to the appropriate board or agency, the commissioner shall obtain the enrollee's permission.

Subd. 4. **Record keeping.** Each health maintenance organization shall maintain records of all quality of care complaints and their resolutions. These records shall be retained for five years and notwithstanding section 145.64, shall be made available to the commissioner upon request. Information provided to the commissioner pursuant to this subdivision shall be classified as confidential data on individuals as defined in section 13.02, subdivision 2.

Sec. 4. **MEDICALLY NECESSARY CARE DEFINITION FOR HEALTH MAINTENANCE ORGANIZATIONS.**

The commissioner of health shall convene a work group to develop a uniform definition of medically necessary care for health maintenance organizations to utilize when determining the medical necessity, appropriateness, or efficacy of a health care service or procedure, and a uniform process for each health maintenance organization to follow when making such an initial determination or utilization review.

By January 15, 2017, the commissioner shall make recommendations, including draft legislation, to the chairs and ranking minority members of the legislative committees with jurisdiction over health care on the proposed uniform definition and determination process, and a process in which the commissioner may periodically review the medically necessary care determinations to ensure that the determinations made by a health maintenance organization adheres to the uniform definition and process.