

CHAPTER 358--S.F.No. 3780

ARTICLE 2 HEALTH CARE HOMES

Section 1. [256B.0751] HEALTH CARE HOMES.

Subdivision 1. **Definitions.** (a) For purposes of sections 256B.0751 to 256B.0753, the following definitions apply.

(b) "Commissioner" means the commissioner of human services.

(c) "Commissioners" means the commissioner of human services and the commissioner of health, acting jointly.

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

4.

(e) "Personal clinician" means a physician licensed under chapter 147, a physician assistant registered and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

(f) "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 2. **Development and implementation of standards.** (a) By July 1, 2009, the commissioners of health and human services shall develop and implement standards

of certification for health care homes for state health care programs. In developing these

standards, the commissioners shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the

commissioners must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and

family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate

in decision making and care plan development, and providing care that is appropriate to

the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's

condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an

assessment

of health risks and chronic conditions;

(6) enable and encourage utilization of a range of qualified health care professionals,

including dedicated care coordinators, in a manner that enables providers to practice to

the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated

benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioners shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates. The commissioners may satisfy this requirement by continuing the provider

directed care coordination advisory committee.

(c) For the purposes of developing and implementing these standards, the commissioners may use the expedited rulemaking process under section 14.389.

Subd. 3. **Requirements for clinicians certified as health care homes.** (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the

criteria of a health care home. In order to be certified as a health care home, a clinician or

clinic must meet the standards set by the commissioners in accordance with this section.

Certification as a health care home is voluntary. In order to maintain their status as health

care homes, clinicians or clinics must renew their certification annually.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 5.

Subd. 4. **Alternative models.** Nothing in this section shall preclude the continued development of existing medical or health care home projects currently operating or under

development by the commissioner of human services or preclude the commissioner

from
establishing alternative models and payment mechanisms for persons who are
enrolled
in integrated Medicare and Medicaid programs under section 256B.69, subdivisions
23
and 28, are enrolled in managed care long-term care programs under section
256B.69,
subdivision 6b, are dually eligible for Medicare and medical assistance, are in the
waiting
period for Medicare, or who have other primary coverage.

Subd. 5. **Health care home collaborative.** By July 1, 2009, the commissioners
shall establish a health care home collaborative to provide an opportunity for health
care
homes and state agencies to exchange information related to quality improvement
and
best practices.

Subd. 6. **Evaluation and continued development.** (a) For continued certification
under this section, health care homes must meet process, outcome, and quality
standards as
developed and specified by the commissioners. The commissioners shall collect data
from
health care homes necessary for monitoring compliance with certification standards
and
for evaluating the impact of health care homes on health care quality, cost, and
outcomes.

(b) The commissioners may contract with a private entity to perform an evaluation
of
the effectiveness of health care homes. Data collected under this subdivision is
classified
as nonpublic data under chapter 13.

Subd. 7. **Outreach.** Beginning July 1, 2009, the commissioner shall encourage
state
health care program enrollees who have a complex or chronic condition to select a
primary
care clinic with clinicians who have been certified as health care homes.

Sec. 2. **[256B.0752] HEALTH CARE HOME REPORTING** **REQUIREMENTS.**

Subdivision 1. **Annual reports on implementation and administration.** The
commissioners shall report annually to the legislature on the implementation and
administration of the health care home model for state health care program enrollees
in the
fee-for-service, managed care, and county-based purchasing sectors beginning
December
15, 2009, and each December 15 thereafter.

Subd. 2. **Evaluation reports.** The commissioners shall provide to the legislature

comprehensive evaluations of the health care home model three years and five years after

implementation. The report must include:

(1) the number of state health care program enrollees in health care homes and the number and characteristics of enrollees with complex or chronic conditions, identified

by income, race, ethnicity, and language;

(2) the number and geographic distribution of health care home providers;

(3) the performance and quality of care of health care homes;

(4) measures of preventive care;

(5) health care home payment arrangements, and costs related to implementation and payment of care coordination fees;

(6) the estimated impact of health care homes on health disparities; and

(7) estimated savings from implementation of the health care home model for the fee-for-service, managed care, and county-based purchasing sectors.

Sec. 3. [256B.0753] PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

Subdivision 1. **Development.** The commissioner of human services, in coordination with the commissioner of health, shall develop a payment system that provides per-person care coordination payments to health care homes certified under section 256B.0751 for providing care coordination services and directly managing on-site or employing care coordinators. The care coordination payments under this section are in addition to the quality incentive payments in section 256B.0754, subdivision 1. The care coordination payment system must vary the fees paid by thresholds of care complexity, with the highest fees being paid for care provided to individuals requiring the most intensive care coordination. In developing the criteria for care coordination payments, the commissioner shall consider the feasibility of including the additional time and resources needed by patients with limited English-language skills, cultural differences, or other barriers to health care. The commissioner may determine a schedule for phasing in care coordination fees such that the fees will be applied first to individuals who have, or are at risk of developing, complex or chronic health conditions. Development of the payment system must be completed by January 1, 2010.

Subd. 2. **Implementation.** The commissioner of human services shall implement care coordination payments as specified under this section by July 1, 2010, or upon federal

approval, whichever is later. For enrollees served under the fee-for-service system, the care coordination payment shall be determined by the commissioner in contracts with certified health care homes. For enrollees served by managed care or county-based purchasing plans, the commissioner's contracts with these plans shall require the payment of care coordination fees to certified health care homes.

Subd. 3. **Cost neutrality.** If initial savings from implementation of health care homes are not sufficient to allow implementation of the care coordination fee in a cost-neutral manner, the commissioner may make recommendations to the legislature on reallocating costs within the health care system.

Sec. 4. **[256B.0754] PAYMENT REFORM.**

Subdivision 1. **Quality incentive payments.** By July 1, 2010, the commissioner of human services shall implement quality incentive payments as established under section 62U.02 for all enrollees in state health care programs consistent with relevant state and federal statute and rule. This section does not limit the ability of the commissioner of human services to establish by contract and monitor, as part of its quality assurance obligations for state health care programs, outcome and performance measures for nonmedical services and health issues likely to occur in low-income populations or racial or cultural groups disproportionately represented in state health care program enrollment that would likely be underrepresented when using traditional measures that are based on longer-term enrollment.

Subd. 2. **Payment reform.** By January 1, 2011, the commissioner of human services shall use the information and methods developed under section 62U.04 to establish a payment system that:

(1) rewards high-quality, low-cost providers;

(2) creates enrollee incentives to receive care from high-quality, low-cost providers;
and

(3) fosters collaboration among providers to reduce cost shifting from one part of the health continuum to another.