..... moves to amend H.F. No. 3045 as follows:

Delete everything after the enacting clause and insert:

"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. **[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 the clinical quality of health care services rendered by a provider, resulting in potential or actual harm to an enrollee. Quality of care complaints include the following, to the extent that they affect the clinical quality of health care services rendered: access, provider and staff competence, appropriateness of care, communications, behavior, facility and environmental considerations, or other factors that impact the clinical quality of health care services.

Subd. 2. **Quality of care complaint investigation.** (a) Each health maintenance organization shall develop and implement policies and procedures for a quality of care complaint investigation process that meets the requirements of this section. The health maintenance organization must have a written policy and procedure for receipt,

investigation, and follow-up of quality of care complaints, including the requirements in paragraphs (b) to (g).

(b) The definition of quality of care complaint in the complaint investigation process must include the concerns identified in subdivision 1.

(c) The complaint investigation process must include a description of levels of severity including:

(1) classification of complaints that warrant peer protection confidentiality as defined by the commissioner under paragraph (h); and

(2) investigation procedures for each level of severity.

(d) Every complaint with an allegation regarding quality of care or service must be investigated by the health maintenance organization. Documentation must show every allegation was addressed.

(e) Conclusions must be supported with evidence that may include an associated corrective action plan implemented and documented and a formal response from a provider to the health plan. The record of investigation must include all related documents, correspondence, summaries, discussions, consultations, and conferences held.

(f) A medical director review must be conducted when there is potential for patient harm.

(g) Quality of care complaints must be tracked and trended for review according to provider and type of quality of care issue: behavior, facility, environmental, and technical competence.

(h) The commissioner, in consultation with any interested stakeholders, shall define complaints that are subject to peer protection confidentiality in accordance with state and federal law by January 1, 2018.

Subd. 3. **Complaint reporting.** Each health maintenance organization shall submit to the commissioner, as part of the company's annual filing, data on the number of complaints and the category as defined by the commissioner. Categories shall include access, communication and behavior, health plan administration, facilities and environment, coordination of care, and technical competence and appropriateness. The commissioner shall define complaint categories in consultation with interested stakeholders by January 1, 2018.

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 according

to this subdivision shall be classified as a confidential data on individuals as defined in section 13.02, subdivision 3."

Amend the title accordingly