..... moves to amend H.F. No. 1143 as follows:

Delete everything after the enacting clause and insert:

"Section 1. **[256B.0758] ENROLLED PROVIDER NETWORKS.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Demonstration provider" has the meaning provided in section 256B.69, subdivision 2.

(c) "Enrolled provider network" means a health care provider, a group of health care providers, or a partnership between a health care provider and a demonstration provider, which is accountable through a contract with the commissioner for: (1) the quality and coordination of care provided under subdivision 3 to qualified enrollees; and (2) managing the cost of providing this care.

(d) "Health plan company" has the meaning specified in section 62Q.01, subdivision 4.

(e) "Metropolitan statistical area" means a metropolitan area containing a core urban area of 50,000 or more population; consisting of one or more counties including the counties containing the core urban area, as well as any adjacent counties that have a high degree of social and economic integration with the urban core.

(f) "Qualified enrollee" means an individual who is enrolled in medical assistance under a families and children eligibility category, or as an adult without children under section 256B.055, subdivision 15, or enrolled in the MinnesotaCare program under chapter 256L.

Subd. 2. **Establishment of reformed health care delivery system.** (a) The commissioner shall implement, by January 1, 2012, or upon federal approval, whichever is later, a reformed health care delivery system for qualified medical assistance and MinnesotaCare enrollees that delivers basic health care services through enrolled provider networks in metropolitan statistical areas (MSAs), and supplements this coverage with a

policy that provides coverage for non-basic care services. Health care providers outside of a metropolitan statistical area may serve as an enrolled provider network and receive total cost of care payments under subdivision 3.

(b) No later than July 1, 2012, or upon federal approval, the commissioner shall discontinue contracts with managed care under sections 256B.69 and 256L.12 for the provision of services to qualified enrollees within a metropolitan statistical area.

Subd. 3. **Provision of basic care services through enrolled provider networks.** (a) The commissioner shall enter into contracts with enrolled provider networks in metropolitan statistical areas, and may enter into contracts with enrolled provider networks outside of a metropolitan statistical area, to provide qualified enrollees with the basic care services specified in paragraph (b), in return for receiving a per-enrollee, concurrently risk-adjusted, total cost of care payment.

(b) Enrolled provider networks under contract with the commissioner shall provide, contract for, and coordinate the following basic care services:

(1) preventive services;

(2) inpatient hospital services, and physician and other health care professional services associated with an inpatient hospital stay;

(3) outpatient hospital services;

(4) freestanding ambulatory surgical center services;

(5) outpatient physician and clinic visits;

(6) lab, x-ray, and diagnostic services;

(7) diabetic care services;

(8) mental healthcare;

(9) vision care, with eyeglasses covered as provided under subdivision 8;

(10) prescription drugs;

(11) medication therapy management;

(12) emergency room care;

(13) immunizations and vaccines;

(14)rehabilitative therapy;

(15) urgent care;

(16) home care; and

(17) hospice care.

(c) An enrolled provider network may provide qualified enrollees with services that are in addition to those listed in paragraph (b).

(d) No enrollee cost-sharing shall be applied to the services listed in paragraph (b)

(e) An enrolled provider network must coordinate the services provided under paragraph (b) with any non-basic care services that an enrollee receives under subdivision 6.

(f) An enrolled provider network may contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services by the enrolled provider network.

(g) If an enrolled provider network does not enter into a contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services, the commissioner shall, by competitive bid, award a contract with a health plan company, county-based purchasing plan, or other entity to administer the provision of basic care services by enrolled provider networks and non-basic care services described in subdivision 6.

(h) Administrators of basic care services must:

(1) collect data on the utilization and cost of health care services provided by each enrolled provider network, and on administrative and other costs incurred by each enrolled provider network, and make this information available to enrolled provider networks and the commissioner;

(2) assist enrolled provider networks and the commissioner in identifying high-cost enrollees;

(3) evaluate the quality of services, as defined by the commissioner, provided by enrolled provider networks, and report this information to enrolled provider networks and the commissioner;

(4) ensure access for enrollees to non-basic care services. The administrator shall report to the commissioner any access concerns which may arise under the reformed health care delivery system; and

(5) evaluate enrollee experience and satisfaction, in a manner determined by the commissioner, and report this information to enrolled provider networks and the commissioner.

Data reported to the third-party administrator and the commissioner under this paragraph are public data as defined in section 13.02, except that data on individuals are classified as private data.

(i) The commissioner shall report annually to the legislature, beginning January 1, 2013 and each January 1 thereafter, on the cost, utilization, administrative expenses, quality, and experience of qualified enrollees receiving services through an enrolled provider network, compared to other enrollees.

Subd. 4. **Enrollee selection of enrolled provider network.** (a) A qualified enrollee within a metropolitan statistical area (MSA) must select an enrolled provider network in order to receive services covered under this section. The commissioner shall assign an enrollee to an enrolled provider network based on greatest percentage of services recently provided to that enrollee, or proximity, if the enrollee does not make a choice. An enrollee must agree to receive all nonemergency covered services through the enrolled provider network, except for non-basic care services covered under subdivision 6.

(b) An enrollee covered through an enrolled provider network has the right to appeal to the commissioner according to section 256.045.

Subd. 5. **Non-MSA providers.** The commissioner of human services may consider payment mechanisms with providers that allow the commissioner to achieve cost-savings, including but not limited to gain sharing arrangements with a county or group of providers, baskets of care, and other payment mechanisms the commissioner determines would improve the quality and efficiency of service delivery to qualified enrollees residing outside of a metropolitan statistical area.

Subd. 6. **Non-basic care coverage.** (a) Non-basic care services must include the following:

(1) emergency and nonemergency medical transportation services;

(2) alcohol and drug treatment;

(3) chiropractic care;

(4) dental care, with dental services provided to nonpregnant adults subject to an annual limit of $.....;

(5) eyeglasses, subject ot an annual limit of $.....;

(6) hearing aids;

(7) interpreter services;

(8) medical equipment and supplies; and

(9) services provided in nursing facilities, intermediate facilities for persons with developmental disabilities, and other long-term care settings.

(b) An enrolled provider network may contract with a health plan company, county-based purchasing plan, or other entity to include the coverage and coordination of non-basic care services in their contract with the commissioner.

(c) No enrollee cost-sharing shall apply to coverage under the non-basic care policy.

(d) The commissioner may require an enrolled provider network to enter into a risk/gain-sharing agreement, under which the enrolled provider network shall be financially responsible for a portion of the risk-adjusted non-basic care costs incurred by qualified enrollees.

Subd. 7. **Premiums.** (a) MinnesotaCare enrollees receiving benefits under this section must pay premiums as provided in section 256L.15.

(b) Medical assistance enrollees receiving benefits under this section shall pay premiums based on the MinnesotaCare sliding premium scale, as established under section 256L.15.

Subd. 8. **Federal approval.** The commissioner shall seek any necessary federal waivers and approvals necessary to implement this section."

Delete the title and insert:

"A bill for an act

relating to human services; requiring certain medical assistance enrollees and all MinnesotaCare enrollees to receive basic services through an enrolled provider network; providing non-basic care services through contract; proposing coding for new law in Minnesota Statutes, chapter 256B."