SENATE
STATE OF MINNESOTA
EIGHTY-NINTH SESSION

S.F. No. 2809

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DATE	D-PG	OFFICIAL STATUS
03/17/2016		Introduction and first reading Referred to Health, Human Services and Housing

1.1 A bill for an act
1.2 relating to health care; establishing a Primary Care Case Management program;
1.3 authorizing direct state contracting with health care providers; proposing coding
1.4 for new law in Minnesota Statutes, chapter 256.

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

1.6 Section 1. **[256.9631] PRIMARY CASE MANAGEMENT AND DIRECT**
1.7 **CONTRACTING FOR MEDICAL ASSISTANCE AND MINNESOTACARE.**

1.8 Subdivision 1. **Program established.** The Primary Care Case Management (PCCM)
1.9 program is established to achieve better health outcomes, track health care expenditures,
1.10 and reduce the cost of health care for the state. The commissioner shall contract directly
1.11 with health care providers to provide services under the PCCM program for medical
1.12 assistance and MinnesotaCare enrollees. Individuals eligible for the PCCM program are
1.13 individuals eligible for medical assistance under section 256B.055 and MinnesotaCare
1.14 enrollees under section 256L.05.

1.15 Subd. 2. **Case management.** (a) The commissioner shall utilize the PCCM
1.16 program to coordinate services for medical assistance and MinnesotaCare enrollees.
1.17 Under the program, patients may choose a primary care provider to act as the enrollee's
1.18 case manager. Primary care physicians, clinics, nurses, and other qualified medical
1.19 professionals may provide primary care case management. Specialists who routinely
1.20 provide care for patients with specific or complex medical conditions may also be primary
1.21 care providers for purposes of case management.

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

2.1 (1) children;

2.2 (2) adults;

2.3 (3) people with disabilities or chronic or complex medical conditions;

2.4 (4) people from communities of color and racial, ethnic, cultural, and other
2.5 socioeconomic groups that face health disparities; and

2.6 (5) the elderly.

2.7 The commissioner shall set higher primary care case management fees based on the
2.8 level of medical and social complexity for patients with chronic or complex conditions
2.9 or disabilities as well as patients who have other challenges due to poverty, or other
2.10 socioeconomic factors that lead to health disparities.

2.11 (c) The primary care provider (PCP) shall provide overall oversight of the enrollee's
2.12 health and coordinate with any other case manager of the enrollee as well as ensure
2.13 24-hour access to health care, emergency treatment, and referrals.

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

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

2.22 Subd. 3. **Duties.** (a) For enrollees, the commissioner shall:

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

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

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

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

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

2.29 (2) track health care targets which include:

2.30 (i) improved health outcomes for enrollees;

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

2.33 (iii) improved care coordination;

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

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

3.1 (c) For providers, the commissioner shall:

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

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

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

3.6 **EFFECTIVE DATE.** This section is effective the day following final enactment.
3.7 Contracts for the Primary Care Case Management program shall be effective when the
3.8 current contracts for medical assistance and MinnesotaCare services expire.