HOUSE RESEARCH

Bill Summary

File Number: H.F. 237 **Date:** January 31, 2017
Version: First engrossment

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Subject: North Memorial Health Care Pilot

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Overview

This bill expands the scope and makes other changes to a health care delivery pilot program that is created by, or includes, North Memorial Health Care.

Section

1 **Health care delivery pilot program.** Amends § 256B.0758.

Subd. 1. Pilot projects. The amendment to paragraph (a) requires the commissioner to establish a health care delivery pilot program that includes, but is not limited to, a community-based collaborative care network created by or including North Memorial Health Care. (Current law allows the commissioner to establish the program.) Requires the program to target groups with a higher incidence of poor health due to medical, economic, behavioral health, cultural, and geographical risk factors.

The amendment to paragraph (b) expands eligibility for the pilot program to MinnesotaCare enrollees (only MA enrollees are included under current law). The amendment also requires the program to serve individuals who reside in the service area of the care network, have multiple risk factors identified by the care network and approved by the commissioner, and have agreed to participate in the pilot project. The commissioner is also allowed to identify potentially eligible individuals based on geographic designations (in addition to zip code), diagnosis, utilization history, or other factors.

A new paragraph (d) limits the pilot program to North Memorial Health Care's care network and up to five additional community-based care network pilot projects.

Section

Specifies criteria the commissioner must consider when selecting the additional pilot projects. Requires the commissioner to seek to authorize at least one rural pilot, at least one community-based primary care safety net pilot, and at least one behavioral health-focused pilot.

Subd. 2. Requirements related to integrated health partnerships. (a) Provides that the commissioner may require care networks to meet the conditions and requirements for integrated health networks, except that:

(1) standardized quality of care and patient satisfaction standards must be waived, changed, or risk-adjusted based on the various risk factors of the patients served;

(2) care networks must be paid a care coordination fee of at least $12 per person per month, in addition to other payments or gain-sharing that would otherwise be received;

(3) patient attribution shall be based on pilot project participants;

(4) requirements related to having a minimum number of participants do not apply; and

(5) the commissioner may waive or modify requirements that discourage participation by rural, independent, community-based, and safety net providers.

(b) Allows an existing integrated health partnership that meets pilot program requirements to participate in the pilot program, and to qualify for the integrated health partnership exceptions.

(c) States the pilot projects are eligible to receive the information and data provided by the commissioner to integrated health partnerships.

Subd. 3. Payment and quality measurement reforms. Requires the commissioner, in consultation with the commissioner of health, care networks, and organizations with expertise serving the patients and communities identified in this section, to design and administer the pilot project in a manner that allows the testing and evaluation of new care models, payment methods, and quality of care measures to determine if they improve outcomes and reduce costs for high-risk Minnesota health care program enrollees and reduce administrative burdens and costs for providers and state agencies.