HOUSE RESEARCH

Bill Summary

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Authors: Hamilton and others

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Analyst: Randall Chun
Elisabeth Klarqvist

Overview

This bill contains provisions related to the delivery of care to low-income populations with various risk factors associated with poor health. Article 1 requires the commissioner of human services to establish demonstration projects to serve low-income, at-risk populations. Article 2 requires managed care and county-based purchasing plans to pay providers based on a minimum provider payment fee schedule, and also requires the commissioner to submit to the legislature a final report on payments methods that into account health disparities. Article 3 modifies requirements for the Statewide Quality Reporting and Measurement System (SQRMS), a system administered by the commissioner of health which measures health care quality based on data reported to the commissioner by health care providers and facilities. Article 4 modifies the Electronic Health Records System Loan Program administered by the commissioner, by expanding the entities eligible for funds and allowing the commissioner to provide grants under the program, in addition to loans.

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Article 1: Payment Reform Pilot Projects

1 **Demonstration projects for complex patient populations.** Amends § 256B.0755, by adding subd. 8. (a) Requires the commissioner to establish special demonstration projects for care networks to serve patient populations with poorer health, higher risks of chronic disease, and poor quality and outcomes of care, due to specified risk factors.

(b) In order to be eligible to be served by a pilot project, requires individuals to be eligible for MA or MinnesotaCare, reside in the service area of the care network, have multiple risk factors, and agree to participate.

(c) Specifies requirements for care networks.

(d) Directs the commissioner to waive or modify conditions and requirements for integrated health partnerships that may be a barrier to testing new care delivery models for high-risk, complex populations. Specifies these new conditions and modified requirements.

(e) Allows the commissioner, in consultation with the commissioner of health, to authorize care networks to test workforce models to improve health outcomes or reduce health care costs. Allows the commissioner to waive enrollment, credentialing, or reimbursement conditions or requirements, and to establish or modify payment methods.

(f) Allows an existing integrated health partnership to participate in the pilot project, and provides that the integrated health partnership qualifies for the exceptions in paragraph (e).

States the pilot projects are eligible to receive the information and data available to integrated health networks.

(g) Requires the commissioners of health and human services, in consultation with care networks and other organizations, to test new methods of measuring provider performance and providing payment incentives to improve health outcomes and reduce administrative burdens for providers and state agencies. Specifies requirements for these incentives and performance measures.

(h) States that a health care provider participating in a pilot project remains eligible to receive any other payments authorized by law, rule, or policy, unless the provider and the commissioner have mutually agreed to an alternative payment method. Directs the commissioner to require managed care organizations under contract to continue to make payments to a provider participating in a pilot project for services provided to MA and MinnesotaCare enrollees.

Article 2: Adequacy of Managed Care Payments

1 **Payment rates.** Amends § 256B.69, by adding subd. 36. Requires the commissioner to develop a minimum provider payment fee schedule for managed care plans and county-based purchasing plans to use in reimbursing health care providers for services provided to MA and MinnesotaCare enrollees. Requires plans to pay health care providers at least the minimum amount specified, and sets this minimum at 110 percent of the base payment amount that applies to services provided to persons not enrolled in a managed care or county-based

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purchasing plan. Specifies criteria related to the base payment amount. Requires plans to document compliance to the commissioner. Provides a definition of "health care provider."

2 **Health disparities payment enhancement.** Amends Laws 2015, chapter 71, article 11, section 63. Requires the commissioner of human services to submit a final report on payment methodologies that incorporate health disparities, an implementation plan, and an implementation budget to the chairs and ranking minority members with jurisdiction over health care policy and finance by December 1, 2017.

Article 3: Reforms to Provider Payments and Quality Standards

1 **Development.** Amends § 62U.02, subd. 1. Makes the following changes to a subdivision directing the commissioner to develop measures to assess the quality of health care services offered by providers:

- requires consumer participation in development of the quality measures;
- removes language that specified content for the initial set of measures;
- requires the measures to address health improvement, in addition to health care outcomes;
- requires the commissioner to stratify quality measures by a population health risk index factor that takes into account factors outside the provider's control that affect patient health and provider performance on quality measures (current law authorizes, but does not require, the commissioner to require that measures be stratified based on sociodemographic factors); and
- strikes a sentence requiring the commissioner to implement the stratification requirement in coordination with Minnesota Community Measurement.

2 **Quality incentive payments.** Amends § 62U.02, subd. 2. In a subdivision requiring the commissioner to develop a quality incentive payment system for providers, requires the payment system to factor out nonclinical factors that affect provider quality measures scores, including factors listed in subdivision 1 (factors such as poverty, neighborhood or region of residence, homelessness, co-occurring mental health and substance use disorders, and other sociodemographic factors).

3 **Quality transparency.** Amends § 62U.02, subd. 3. Allows the system for risk adjusting quality measures to be based on the population health risk index factor established in subdivision 1 or segmentation of providers based on characteristics of patient populations served (in addition to an actual-to-expected comparison of the patient population served by the clinic or hospital, as in current law). Requires the commissioner to ensure that quality data reporting requirements do not duplicate quality measures established for the Medicare or Medicaid program, or specific measures available from other sources.

4 **Contracting.** Amends § 62U.02, subd. 4. Current law allows the commissioner to contract with a nonprofit private entity or consortium to conduct quality measurement and reporting activities. This section removes the nonprofit requirement, and allows the commissioner to contract with more than one entity or consortium for these activities.

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5 **Performance reporting and quality improvement system.** Amends § 256B.072. (a) Requires the commissioner to develop alternative performance measures for providers who primarily serve patients who are uninsured or enrolled in Minnesota health care programs, and display socioeconomic characteristics associated with poor health outcomes. Gives providers the option to have their performance measured using these alternative measures, effective July 1, 2018. Requires the commissioner to develop and use alternative measures for all provider performance reporting initiatives administered by the commissioner.

(b) Lists requirements for the alternative performance measures.

(c) Requires the alternative measures to be developed and used for all:

(1) public reporting of provider performance;

(2) provider quality measurement and payment rate determinations under fee-for-service, managed care, and county-based purchasing; and

(3) provider quality measurement and payment rate determinations under value-based purchasing and care coordination arrangements, including but not limited to health care homes, the health care delivery system (integrated health partnership) demonstration project, and the Hennepin County integrated health care delivery pilot program.

(d) Requires the commissioner to establish provider eligibility criteria for the alternative performance measurement system, and a process for providers to opt-in. Allows the commissioner to require additional information from providers to determine eligibility for the alternative system, and to measure provider performance using alternative measures.

Article 4: Health Information Technology Grants

1 **Account establishment.** Amends § 62J.496, subd. 1. Amends a subdivision establishing the electronic health record system revolving account, which makes loans to health care providers and facilities to support electronic health records activities, to also allow account funds to be used to improve the use of health information technology to support new health care delivery models and payment models. Makes conforming changes to allow grants to be provided from this account, in addition to loans.

2 **Eligibility.** Amends § 62J.496, subd. 2. Makes conforming changes to allow grants to be provided through the electronic health record program. Expands the entities eligible for grants and loans, to include community-based mental health, substance use disorder, or dental providers who are not part of a large health system, corporation, or practice. Modifies the priorities for providing grants and loans, to include entities that are community-based and serve a high proportion of public health care program enrollees or patients who are uninsured or underinsured.

3 **Technology grants.** Amends § 62J.496, by adding subd. 5. In addition to administering the loan program under this section, also directs the commissioner to award grants under this section to eligible grantees. Requires grants to be awarded from money appropriated for this section or from money obtained from other sources.