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## State of Minnesota

## HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 1208

02/25/2015 Authored by Zerwas, Loeffler, Backer and Kahn

The bill was read for the first time and referred to the Committee on Health and Human Services Reform

03/16/2015 Adoption of Report: Amended and re-referred to the Committee on Civil Law and Data Practices

1.1 A bill for an act  
1.2 relating to health; requiring health care quality measures and payment methods  
1.3 to identify and adjust for health disparities related to race, ethnicity, language,  
1.4 and sociodemographic risk factors; appropriating money; amending Minnesota  
1.5 Statutes 2014, sections 62U.02, subdivisions 1, 2, 3, 4; 256B.072.

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

1.7 Section 1. Minnesota Statutes 2014, section 62U.02, subdivision 1, is amended to read:

1.8 Subdivision 1. **Development.** (a) The commissioner of health shall develop a  
1.9 standardized set of measures by which to assess the quality of health care services offered  
1.10 by health care providers, including health care providers certified as health care homes  
1.11 under section 256B.0751. Quality measures must be based on medical evidence and be  
1.12 developed through a process in which providers participate. The measures shall be used  
1.13 for the quality incentive payment system developed in subdivision 2 and must:

1.14 (1) include uniform definitions, measures, and forms for submission of data, to the  
1.15 greatest extent possible;

1.16 (2) seek to avoid increasing the administrative burden on health care providers;

1.17 (3) be initially based on existing quality indicators for physician and hospital  
1.18 services, which are measured and reported publicly by quality measurement organizations,  
1.19 including, but not limited to, Minnesota Community Measurement and specialty societies;

1.20 (4) place a priority on measures of health care outcomes, rather than process  
1.21 measures, wherever possible; ~~and~~

1.22 (5) incorporate measures for primary care, including preventive services, coronary  
1.23 artery and heart disease, diabetes, asthma, depression, and other measures as determined  
1.24 by the commissioner; and

2.1 (6) effective July 1, 2016, be stratified by race, ethnicity, preferred language,  
2.2 and country of origin. On or after January 1, 2018, the commissioner may require  
2.3 measures to be stratified by other sociodemographic factors that, according to reliable  
2.4 data, are correlated with health disparities and have an impact on performance, quality,  
2.5 or cost indicators. New methods of stratifying data under this clause must be tested  
2.6 and evaluated through pilot projects prior to adding them to the statewide system, with  
2.7 separate evaluations for each quality measure affected. In determining whether to add  
2.8 additional sociodemographic factors and developing the methodology to be used, the  
2.9 commissioner shall consider the reporting burden on providers and determine whether  
2.10 there are alternative sources of data that could be used. The commissioner shall ensure  
2.11 that categories and data collection methods are developed in consultation with those  
2.12 communities impacted by health disparities using culturally appropriate community  
2.13 engagement principles and methods. The commissioner shall implement this clause in  
2.14 coordination with the contracting entity retained under subdivision 4 in order to build  
2.15 upon the data stratification methodology that has been developed and tested by the entity.  
2.16 Nothing in this clause expands or changes the commissioner's authority to collect, analyze,  
2.17 or report health care data. Any data collected to implement this clause must be data that is  
2.18 available or is authorized to be collected under other laws. Nothing in this clause grants  
2.19 authority to the commissioner to collect or analyze patient-level or patient-specific data  
2.20 of the patient characteristics identified under this clause.

2.21 (b) The measures shall be reviewed at least annually by the commissioner.

2.22 Sec. 2. Minnesota Statutes 2014, section 62U.02, subdivision 2, is amended to read:

2.23 Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner  
2.24 shall develop a system of quality incentive payments under which providers are eligible  
2.25 for quality-based payments that are in addition to existing payment levels, based upon  
2.26 a comparison of provider performance against specified targets, and improvement over  
2.27 time. The targets must be based upon and consistent with the quality measures established  
2.28 under subdivision 1.

2.29 (b) To the extent possible, the payment system must adjust for variations in patient  
2.30 population in order to reduce incentives to health care providers to avoid high-risk patients  
2.31 or populations, including those with risk factors related to race, ethnicity, language,  
2.32 country of origin, and sociodemographic factors.

2.33 (c) The requirements of section 62Q.101 do not apply under this incentive payment  
2.34 system.

3.1 Sec. 3. Minnesota Statutes 2014, section 62U.02, subdivision 3, is amended to read:

3.2 Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards  
3.3 for measuring health outcomes, establish a system for risk adjusting quality measures,  
3.4 and issue annual public reports on provider quality beginning July 1, 2010. By January  
3.5 1, 2010, physician clinics and hospitals shall submit standardized electronic information  
3.6 on the outcomes and processes associated with patient care to the commissioner or the  
3.7 commissioner's designee. In addition to measures of care processes and outcomes, the  
3.8 report may include other measures designated by the commissioner, including, but not  
3.9 limited to, care infrastructure and patient satisfaction. The commissioner shall ensure  
3.10 that any quality data reporting requirements established under this subdivision are not  
3.11 duplicative of publicly reported, communitywide quality reporting activities currently  
3.12 under way in Minnesota. Nothing in this subdivision is intended to replace or duplicate  
3.13 current privately supported activities related to quality measurement and reporting in  
3.14 Minnesota.

3.15 (b) Effective July 1, 2017, the risk adjustment system established under this  
3.16 subdivision shall adjust for patient characteristics identified under subdivision 1,  
3.17 paragraph (a), clause (6), that are correlated with health disparities and have an impact  
3.18 on performance, cost, and quality measures. The risk adjustment method may consist of  
3.19 reporting based on an actual-to-expected comparison that reflects the characteristics of the  
3.20 patient population served by the clinic or hospital. The commissioner shall implement this  
3.21 paragraph in coordination with any contracting entity retained under subdivision 4.

3.22 Sec. 4. Minnesota Statutes 2014, section 62U.02, subdivision 4, is amended to read:

3.23 Subd. 4. **Contracting.** The commissioner may contract with a private entity or  
3.24 consortium of private entities to complete the tasks in subdivisions 1 to 3. The private  
3.25 entity or consortium must be nonprofit and have governance that includes representatives  
3.26 from the following stakeholder groups: health care providers, including providers serving  
3.27 high concentrations of patients and communities impacted by health disparities, health  
3.28 plan companies, consumers, including consumers representing groups who experience  
3.29 health disparities, employers or other health care purchasers, and state government. No  
3.30 one stakeholder group shall have a majority of the votes on any issue or hold extraordinary  
3.31 powers not granted to any other governance stakeholder.

3.32 Sec. 5. Minnesota Statutes 2014, section 256B.072, is amended to read:

3.33 **256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT**  
3.34 **SYSTEM.**

4.1 (a) The commissioner of human services shall establish a performance reporting  
4.2 system for health care providers who provide health care services to public program  
4.3 recipients covered under chapters 256B, 256D, and 256L, reporting separately for  
4.4 managed care and fee-for-service recipients.

4.5 (b) The measures used for the performance reporting system for medical groups  
4.6 shall include measures of care for asthma, diabetes, hypertension, and coronary artery  
4.7 disease and measures of preventive care services. The measures used for the performance  
4.8 reporting system for inpatient hospitals shall include measures of care for acute myocardial  
4.9 infarction, heart failure, and pneumonia, and measures of care and prevention of surgical  
4.10 infections. In the case of a medical group, the measures used shall be consistent with  
4.11 measures published by nonprofit Minnesota or national organizations that produce and  
4.12 disseminate health care quality measures or evidence-based health care guidelines. In  
4.13 the case of inpatient hospital measures, the commissioner shall appoint the Minnesota  
4.14 Hospital Association and Stratis Health to advise on the development of the performance  
4.15 measures to be used for hospital reporting. To enable a consistent measurement process  
4.16 across the community, the commissioner may use measures of care provided for patients in  
4.17 addition to those identified in paragraph (a). The commissioner shall ensure collaboration  
4.18 with other health care reporting organizations so that the measures described in this  
4.19 section are consistent with those reported by those organizations and used by other  
4.20 purchasers in Minnesota.

4.21 (c) The commissioner may require providers to submit information in a required  
4.22 format to a health care reporting organization or to cooperate with the information collection  
4.23 procedures of that organization. The commissioner may collaborate with a reporting  
4.24 organization to collect information reported and to prevent duplication of reporting.

4.25 (d) By October 1, 2007, and annually thereafter, the commissioner shall report  
4.26 through a public Web site the results by medical groups and hospitals, where possible,  
4.27 of the measures under this section, and shall compare the results by medical groups and  
4.28 hospitals for patients enrolled in public programs to patients enrolled in private health  
4.29 plans. To achieve this reporting, the commissioner may collaborate with a health care  
4.30 reporting organization that operates a Web site suitable for this purpose.

4.31 (e) Performance measures must be stratified as provided under section 62U.02,  
4.32 subdivision 1, paragraph (a), clause (6), and risk-adjusted as specified in section 62U.02,  
4.33 subdivision 3, paragraph (b).

4.34 Sec. 6. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

5.1 (a) The commissioner of human services shall develop a legislative proposal for a  
5.2 new methodology to pay a higher payment rate for primary care, medical, mental health,  
5.3 dental, and hospital services that takes into consideration the higher cost, complexity, and  
5.4 resources needed to serve patients and populations who experience the greatest health  
5.5 disparities in order to achieve the same health and quality outcomes that are achieved for  
5.6 other patients and populations.

5.7 (b) In developing the methodology, the commissioner of human services shall take  
5.8 into consideration all existing medical assistance, MinnesotaCare, and basic health plan  
5.9 payment methods and rates, including add-on or enhanced rates paid to some providers,  
5.10 including critical access dental, community clinic add-ons, and federally qualified health  
5.11 centers payment rates. The new methodology must not result in a net decrease in total  
5.12 payment from all sources for the types of providers who qualify for additional add-on  
5.13 payments or enhanced payments. Payments for rural health clinic and federally qualified  
5.14 health center services shall be made according to applicable federal law and regulation.

5.15 (c) The commissioner of human services shall evaluate the extent to which the  
5.16 new payment methodology can be developed and tested using data that is available to  
5.17 the commissioner from existing sources or through the commissioner of health. The  
5.18 commissioner of human services shall complete the report and develop the proposed  
5.19 methodology using data from existing state sources to the extent possible. If additional  
5.20 data sources are needed, the commissioner of human services shall submit proposed  
5.21 legislation to provide the authority to obtain the data that is necessary. The commissioner  
5.22 of health shall assist the commissioner of human services in providing data, expertise, and  
5.23 analysis to develop the report and payment methodology.

5.24 (d) The commissioner of human services shall develop the methodology in  
5.25 consultation with affected stakeholders, including communities impacted by health  
5.26 disparities, using culturally appropriate methods of community engagement. The  
5.27 proposed methodology must include recommendations for how the methodology could be  
5.28 incorporated into payment methods used in both fee-for-service and managed care plans.

5.29 (e) The commissioner of human services shall submit a report and recommendations,  
5.30 and draft legislative language, to implement the new methodology to the chairs and  
5.31 ranking minority members of the legislative committees with jurisdiction over health care  
5.32 policy and finance, including the proposed methodology for providing a health disparities  
5.33 payment adjustment. The legislative proposal for payment rate changes shall be submitted  
5.34 to the legislature as part of or in conjunction with the commissioner of human services  
5.35 legislative budget and policy proposals to the 2016 legislature for changes to the state's  
5.36 medical assistance program and state purchasing strategy for Minnesota health care

6.1 programs. The report and legislation shall include the proposed process, timeline, and  
6.2 budgetary needs for the data collection, analysis, development, and testing of the new  
6.3 methodology and the target date for implementation.

6.4 Sec. 7. **APPROPRIATIONS.**

6.5 Subdivision 1. **Commissioner of health.** \$..... is appropriated for the biennium  
6.6 ending June 30, 2017, from the general fund to the commissioner of health for the  
6.7 following:

6.8 (1) the development of the quality incentive payment system specified in Minnesota  
6.9 Statutes, section 62U.02, subdivision 1, paragraph (a), clause (6);

6.10 (2) the development of the risk adjustment system specified in Minnesota Statutes,  
6.11 section 62U.02, subdivision 3, paragraph (b); and

6.12 (3) community engagement with those communities impacted by health disparities.

6.13 Subd. 2. **Commissioner of human services.** \$..... is appropriated for the biennium  
6.14 ending June 30, 2017, from the general fund to the commissioner of human services for  
6.15 the modification of provider performance measures under Minnesota Statutes, section  
6.16 256B.072, paragraph (e), to implement stratification and risk adjustment methods.