State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-NINTH SESSION

H. F. No. 3499

03/23/2016 Authored by Zerwas, Hamilton, Loeffler and Moran
The bill was read for the first time and referred to the Committee on Health and Human Services Reform

A bill for an act

relating to health; making changes to the statewide quality and reporting system using measures that correlate with health disparities; amending Minnesota Statutes 2015 Supplement, section 62U.02, subdivisions 1, 3.

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

Section 1. Minnesota Statutes 2015 Supplement, section 62U.02, subdivision 1, is amended to read:

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

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

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

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

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

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

(b) Effective July 1, 2016, the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available. On or after January 1, 2018, the commissioner may ~~require~~ stratify measures ~~to be stratified~~ by other sociodemographic factors or by composites of multiple sociodemographic factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. The commissioner may also stratify measures using composite indicators or proxies that combine multiple sociodemographic factors that are correlated with health disparities. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

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

Sec. 2. Minnesota Statutes 2015 Supplement, section 62U.02, subdivision 3, is amended to read:

Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality beginning July 1, 2010.

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics ~~identified under subdivision 1, paragraph (b),~~ that are correlated with health disparities and have an impact on performance on cost and quality measures, including but not limited to the patient characteristics identified under subdivision 1, paragraph (b). The risk adjustment method may consist of

reporting based on an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. The risk adjustment may be based on composite indicators that are based on multiple sociodemographic factors that are correlated with health disparities, including but not limited to composite proxy indicators based on the patient's address. Data needed for development and implementation of risk adjustment may be obtained from sources other than provider data submitted under paragraph (c). The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

(c) By January 1, 2010, physician clinics and hospitals shall submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, communitywide quality reporting activities currently under way in Minnesota. Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.