State of Minnesota

HOUSE OF REPRESENTATIVES

NINETY-SECOND SESSION

H. F. No. 3696

02/24/2022 Authored by Schultz
The bill was read for the first time and referred to the Committee on Health Finance and Policy

A bill for an act

relating to health; modifying data collected under the all-payer claims database and uses of this data; requiring the commissioner of health to study and report on systems used by health plan companies and third-party administrators to pay health care providers; amending Minnesota Statutes 2020, sections 62U.04, subdivision 11, by adding a subdivision; 62U.10, subdivision 7; Minnesota Statutes 2021 Supplement, section 62U.04, subdivisions 4, 5.

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

Section 1. Minnesota Statutes 2021 Supplement, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) All health plan companies and third-party administrators shall submit encounter data on a monthly basis to a private entity designated by the commissioner of health. The data shall be submitted in a form and manner specified by the commissioner subject to the following requirements:

(1) the data must be de-identified data as described under the Code of Federal Regulations, title 45, section 164.514;

(2) the data for each encounter must include an identifier for the patient's health care home if the patient has selected a health care home, data on contractual value-based payments, and~~, for claims incurred on or after January 1, 2019,~~ data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; and

(3) except for the identifier described in clause (2), the data must not include information that is not included in a health care claim or equivalent encounter information transaction that is required under section 62J.536.

(b) The commissioner or the commissioner's designee shall only use the data submitted under paragraph (a) to carry out the commissioner's responsibilities in this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data on providers collected under this subdivision are private data on individuals or nonpublic data, as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this subdivision may be derived from nonpublic data. The commissioner or the commissioner's designee shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

(d) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Sec. 2. Minnesota Statutes 2021 Supplement, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) All health plan companies and third-party administrators shall submit, on a monthly basis, data on their contracted prices with health care providers to a private entity designated by the commissioner of health for the purposes of performing the analyses required under this subdivision. Data on contracted prices submitted under this paragraph must include data on supplemental contractual value-based payments paid to health care providers. The data shall be submitted in the form and manner specified by the commissioner of health.

(b) The commissioner or the commissioner's designee shall only use the data submitted under this subdivision to carry out the commissioner's responsibilities under this section, including supplying the data to providers so they can verify their results of the peer grouping process consistent with the recommendations developed pursuant to subdivision 3c, paragraph

(d), and adopted by the commissioner and, if necessary, submit comments to the commissioner or initiate an appeal.

(c) Data collected under this subdivision are nonpublic data as defined in section 13.02. Notwithstanding the definition of summary data in section 13.02, subdivision 19, summary data prepared under this section may be derived from nonpublic data. The commissioner shall establish procedures and safeguards to protect the integrity and confidentiality of any data that it maintains.

Sec. 3. Minnesota Statutes 2020, section 62U.04, is amended by adding a subdivision to read:

Subd. 5b. **Non-claims-based, contractual value-based payments.** (a) On October 1 of each year, all health plan companies and third-party administrators shall submit to a private entity designated by the commissioner of health all non-claims-based, contractual value-based payments made to health care providers. The data shall be submitted in a form and manner specified by the commissioner. Non-claims-based, contractual value-based payments include but are not limited to capitation payments, risk-based payments, health care home payments, payments made to develop capacity to improve care to patients with chronic conditions, payments made to support the adoption of health information technology, and payments made for services provided by patient educators, patient navigators, or care managers. Non-claims-based, contractual value-based payments submitted under this subdivision must be attributed to a health care provider in the same manner in which claims-based data is attributed to a health care provider and must be combined with data collected under subdivisions 4 and 5 in analyses of health care spending.

(b) The commissioner shall consult with health plan companies, hospitals, and health care providers in developing the data reported under this subdivision and standardized reporting forms.

Sec. 4. Minnesota Statutes 2020, section 62U.04, subdivision 11, is amended to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), the commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 ~~and~~, 5, and 5b for the following purposes:

(1) to evaluate the performance of the health care home program as authorized under section 62U.03, subdivision 7;

(2) to study, in collaboration with the reducing avoidable readmissions effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, utilization, and illness burden based on geographical areas or populations;

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities; ~~and~~

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015~~.~~; and

(6) for a onetime study of health care payment systems used by health plan companies to pay health care providers and for development of recommendations for changes to health care payment systems to reward value over volume of services, promote health, support primary care and preventive services, and ensure the availability of an adequate health care workforce.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 ~~and~~, 5, and 5b for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Sec. 5. Minnesota Statutes 2020, section 62U.10, subdivision 7, is amended to read:

Subd. 7. **Outcomes reporting; savings determination.** (a) Beginning November 1, 2016, and each November 1 thereafter, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 ~~and~~, 5, and 5b, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Sec. 6. **REPORT ON TRANSPARENCY OF HEALTH CARE PAYMENTS.**

Subdivision 1. **Definitions.** (a) The terms defined in this subdivision apply to this section.

(b) "Capitation" means a health care payment system that pays practitioners and hospitals a set amount for each enrollee assigned to the practitioner or hospital per period of time, whether or not the enrollee seeks care from the practitioner or hospital.

(c) "Commissioner" means the commissioner of health.

(d) "Direct primary care" means a health care payment model in which consumers pay their primary care practitioner or practice directly in the form of a flat monthly or annual fee for a defined set of primary care services.

(e) "Enrollee" means an individual covered by a health plan company or health insurance or health coverage plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

(f) "Fee-for-service payment" means a method of health care payment in which practitioners and hospitals are paid for each specific health care service provided.

(g) "Practitioner" means an individual who is a physician, advanced practice registered nurse, or physician assistant and is currently practicing in Minnesota.

(h) "Primary care practitioner" means an individual who is a physician, advanced practice registered nurse, or physician assistant; is currently practicing in Minnesota; is a direct entry point for patients; and provides a full spectrum of primary care services.

(i) "Primary care services" means integrated, accessible health care services provided by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community. Primary care services include but are not limited to preventive services, office visits, administration of vaccines, annual physicals, pre-operative physicals, assessments, care coordination, development of treatment plans, management of chronic conditions, and diagnostic tests.

(j) "Value-based payment" means a health care payment model in which practitioners and hospitals are reimbursed based on patient health outcomes such as helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.

Subd. 2. **Report.** (a) To provide the legislature with the information needed to meet the evolving health care needs of Minnesotans, the commissioner shall report to the legislature on the current health care payment systems used by health plan companies and shall recommend ways to modify these systems. The commissioner shall prepare this report using data submitted under Minnesota Statutes, section 62U.04; input from stakeholders; and surveys of health plan companies, and shall submit a report to the legislature by December 15, 2022.

(b) In this report, the commissioner shall examine the types of services currently paid for, the use of value-based payments, and whether current payment systems are structured to support a patient-centered, primary care-based, interprofessional team approach to care that promotes better patient outcomes. The report must include:

(1) how payments are currently made to practitioners, including:

(i) the percentage of total claims and the percentage of claims for primary care services that are paid solely on a fee-for-service basis;

(ii) the percentage of total claims and the percentage of claims for primary care services that include a value-based payment and the types of value-based payments used; and

(iii) the percentage of total claims and the percentage of primary care claims that are paid on a total capitation basis or a partial capitation basis, such as direct primary care;

(2) the percentage of total payments made for services that are for primary care services and the percentage of total payments made for services that are for non-primary care services; and

(3) recommendations on changes needed to expedite implementation of a health care payment system that rewards value over volume of services provided, that promotes the health of all Minnesotans, that supports the provision of primary care services and preventive services, and that ensures availability of an adequate health care workforce needed to implement a reformed payment system.