

1.1 A bill for an act

1.2 relating to health; modifying the provider peer grouping timelines and system;  
1.3 amending Minnesota Statutes 2008, sections 62U.04, subdivisions 3, 9;  
1.4 256B.0754, subdivision 2; repealing Minnesota Statutes 2009 Supplement,  
1.5 section 256B.032.

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

1.7 Section 1. Minnesota Statutes 2008, section 62U.04, subdivision 3, is amended to read:

1.8 Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer  
1.9 grouping system for providers based on a combined measure that incorporates both  
1.10 provider risk-adjusted cost of care and quality of care, and for specific conditions as  
1.11 determined by the commissioner. In developing this system, the commissioner shall  
1.12 consult and coordinate with health care providers, health plan companies, state agencies,  
1.13 and organizations that work to improve health care quality in Minnesota. For purposes of  
1.14 the final establishment of the peer grouping system, the commissioner shall not contract  
1.15 with any private entity, organization, or consortium of entities that has or will have a direct  
1.16 financial interest in the outcome of the system.

1.17 (b) ~~Beginning June 1~~ By no later than October 15, 2010, the commissioner shall  
1.18 disseminate information to providers on their total cost of care, total resource use, total  
1.19 quality of care, and the total care results of the grouping developed under this subdivision  
1.20 in comparison to an appropriate peer group. Any analyses or reports that identify  
1.21 providers may only be published after the provider has been provided the opportunity by  
1.22 the commissioner to review the underlying data and submit comments. Providers may be  
1.23 given any data for which they are the subject of the data. The provider shall have ~~21~~ 30  
1.24 days to review the data for accuracy and initiate an appeal as specified in paragraph (d).

2.1 (c) By no later than January 1, 2011, the commissioner shall disseminate information  
2.2 to providers on their condition-specific cost of care, condition-specific resource use,  
2.3 condition-specific quality of care, and the condition-specific results of the grouping  
2.4 developed under this subdivision in comparison to an appropriate peer group. Any  
2.5 analyses or reports that identify providers may only be published after the provider has  
2.6 been provided the opportunity by the commissioner to review the underlying data and  
2.7 submit comments. Providers may be given any data for which they are the subject of the  
2.8 data. The provider shall have 30 days to review the data for accuracy and initiate an  
2.9 appeal as specified in paragraph (d).

2.10 (d) The commissioner shall establish an appeals process to resolve disputes from  
2.11 providers regarding the accuracy of the data used to develop analyses or reports. When  
2.12 a provider appeals the accuracy of the data used to calculate the peer grouping system  
2.13 results, the provider shall:

2.14 (1) clearly indicate the reason they believe the data used to calculate the peer group  
2.15 system results are not accurate;

2.16 (2) provide evidence and documentation to support the reason that data was not  
2.17 accurate; and

2.18 (3) cooperate with the commissioner, including allowing the commissioner access to  
2.19 data necessary and relevant to resolving the dispute.

2.20 If a provider does not meet the requirements of this paragraph, a provider's appeal shall be  
2.21 considered withdrawn. The commissioner shall not publish results for a specific provider  
2.22 under paragraph (e) or (f) while that provider has an unresolved appeal.

2.23 ~~(d)~~ (e) Beginning ~~September 1, 2010~~ January 1, 2011, the commissioner shall, no  
2.24 less than annually, publish information on providers' total cost, total resource use, total  
2.25 quality, and the results of the total care portion of the peer grouping process. The results  
2.26 that are published must be on a risk-adjusted basis.

2.27 (f) Beginning March 30, 2011, the commissioner shall no less than annually  
2.28 publish information on providers' condition-specific cost, condition-specific resource use,  
2.29 condition-specific quality, and the results of the condition-specific portion of the peer  
2.30 grouping process. The results that are published must be on a risk-adjusted basis.

2.31 (g) Prior to disseminating data to providers under paragraph (b) or (c) or publishing  
2.32 information under paragraph (e) or (f), the commissioner shall ensure the scientific  
2.33 validity and reliability of the results according to the standards described in paragraph (h).  
2.34 If additional time is needed to establish the scientific validity and reliability of the results,  
2.35 the commissioner may delay the dissemination of data to providers under paragraph (b) or  
2.36 (c), or the publication of information under paragraph (e) or (f). If the delay is more than

3.1 60 days, the commissioner shall report in writing to the Legislative Commission on Health  
3.2 Care Access the following information:  
3.3 (1) the reason for the delay;  
3.4 (2) the actions being taken to resolve the delay and establish the scientific validity  
3.5 and reliability of the results; and  
3.6 (3) the new dates by which the results shall be disseminated.

3.7 If there is a delay under this paragraph, the commissioner must disseminate the  
3.8 information to providers under paragraph (b) or (c) at least 90 days before publishing  
3.9 results under paragraph (e) or (f).

3.10 (h) The commissioner's assurance of valid and reliable clinic and hospital peer  
3.11 grouping performance results shall include, at a minimum, the following:

3.12 (1) use of the best available evidence, research, and methodologies; and  
3.13 (2) establishment of an explicit minimum reliability threshold developed in  
3.14 collaboration with the subjects of the data and the users of the data, at a level not below  
3.15 nationally accepted standards where such standards exist.

3.16 In achieving these thresholds, the commissioner shall not aggregate clinics that are not  
3.17 part of the same system or practice group. The commissioner shall consult with and solicit  
3.18 feedback from representatives of physician clinics and hospitals during the peer grouping  
3.19 data analysis process to obtain input on the methodological options prior to final analysis  
3.20 and on the design, development, and testing of provider reports.

3.21 Sec. 2. Minnesota Statutes 2008, section 62U.04, subdivision 9, is amended to read:

3.22 Subd. 9. **Uses of information.** (a) By ~~January 1, 2011~~ no later than 12 months after  
3.23 the commissioner publishes the information in subdivision 3, paragraph (e):

3.24 (1) the commissioner of management and budget shall use the information and  
3.25 methods developed under subdivision 3 to strengthen incentives for members of the state  
3.26 employee group insurance program to use high-quality, low-cost providers;

3.27 (2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer  
3.28 health benefits to their employees must offer plans that differentiate providers on their  
3.29 cost and quality performance and create incentives for members to use better-performing  
3.30 providers;

3.31 (3) all health plan companies shall use the information and methods developed  
3.32 under subdivision 3 to develop products that encourage consumers to use high-quality,  
3.33 low-cost providers; and

3.34 (4) health plan companies that issue health plans in the individual market or the  
3.35 small employer market must offer at least one health plan that uses the information

4.1 developed under subdivision 3 to establish financial incentives for consumers to choose  
4.2 higher-quality, lower-cost providers through enrollee cost-sharing or selective provider  
4.3 networks.

4.4 (b) By January 1, 2011, the commissioner of health shall report to the governor  
4.5 and the legislature on recommendations to encourage health plan companies to promote  
4.6 widespread adoption of products that encourage the use of high-quality, low-cost providers.  
4.7 The commissioner's recommendations may include tax incentives, public reporting of  
4.8 health plan performance, regulatory incentives or changes, and other strategies.

4.9 Sec. 3. Minnesota Statutes 2008, section 256B.0754, subdivision 2, is amended to read:

4.10 Subd. 2. **Payment reform.** By ~~January 1, 2011~~ no later than 12 months after the  
4.11 commissioner of health publishes the information in section 62U.04, subdivision 3,  
4.12 paragraph (e), the commissioner of human services shall use the information and methods  
4.13 developed under section 62U.04 to establish a payment system that:

4.14 (1) rewards high-quality, low-cost providers;

4.15 (2) creates enrollee incentives to receive care from high-quality, low-cost providers;

4.16 and

4.17 (3) fosters collaboration among providers to reduce cost shifting from one part of  
4.18 the health continuum to another.

4.19 Sec. 4. **PAYMENT REFORM IMPLEMENTATION REPORT.**

4.20 By April 1, 2011, the commissioner of human services shall report to the chairs of  
4.21 the senate Health and Human Services Budget Division and the house of representatives  
4.22 Health Care and Human Services Finance Division recommendations for implementing  
4.23 the payment reform in Minnesota Statutes, section 256B.0754, subdivision 2. The  
4.24 recommendations shall include:

4.25 (1) legislative changes needed to fully implement this payment reform; and

4.26 (2) an analysis of the fiscal impact of implementing this payment reform.

4.27 Sec. 5. **REPEALER.**

4.28 Minnesota Statutes 2009 Supplement, section 256B.032, is repealed.