CHAPTER 164–S.F.No. 1809

An act relating to health; removing requirements for implementation of evidence-based strategies as part of hospital community benefit programs and health maintenance organizations collaboration plans; changing requirements for development of health care costs and quality outcome standards; providing for use and public release of certain health care data; amending Minnesota Statutes 2010, sections 62U.04, subdivisions 1, 2, 4, 5; 256B.0754, subdivision 2; Minnesota Statutes 2011 Supplement, section 62U.04, subdivisions 3, 9; Laws 2011, First Special Session chapter 9, article 10, section 4, subdivision 2.

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

Section 1. Laws 2011, First Special Session chapter 9, article 10, section 4, subdivision 2, is amended to read:

Subd. 2. **Community and Family Health Promotion**

	Appropriations by Fund	
General	45,577,000	46,030,000
State Government Special Revenue	1,033,000	1,033,000
Health Care Access	16,719,000	1,719,000
Federal TANF	11,713,000	11,713,000

TANF Appropriations. (1) $1,156,000 of the TANF funds is appropriated each year of the biennium to the commissioner for family planning grants under Minnesota Statutes, section 145.925.

(2) $3,579,000 of the TANF funds is appropriated each year of the biennium to the commissioner for home visiting and nutritional services listed under Minnesota Statutes, section 145.882, subdivision 7, clauses (6) and (7). Funds must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1.

(3) $2,000,000 of the TANF funds is appropriated each year of the biennium to

the commissioner for decreasing racial and ethnic disparities in infant mortality rates under Minnesota Statutes, section 145.928, subdivision 7.

(4) $4,978,000 of the TANF funds is appropriated each year of the biennium to the commissioner for the family home visiting grant program according to Minnesota Statutes, section 145A.17. $4,000,000 of the funding must be distributed to community health boards according to Minnesota Statutes, section 145A.131, subdivision 1. $978,000 of the funding must be distributed to tribal governments based on Minnesota Statutes, section 145A.14, subdivision 2a.

(5) The commissioner may use up to 6.23 percent of the funds appropriated each fiscal year to conduct the ongoing evaluations required under Minnesota Statutes, section 145A.17, subdivision 7, and training and technical assistance as required under Minnesota Statutes, section 145A.17, subdivisions 4 and 5.

TANF Carryforward. Any unexpended balance of the TANF appropriation in the first year of the biennium does not cancel but is available for the second year.

Statewide Health Improvement Program. ~~(a)~~ $15,000,000 in the biennium ending June 30, 2013, is appropriated from the health care access fund for the statewide health improvement program and is available until expended. Notwithstanding Minnesota Statutes, sections 144.396, and 145.928, the commissioner may use tobacco prevention grant funding and grant funding under Minnesota Statutes, section 145.928, to support the statewide health improvement program. The commissioner may focus the program geographically or on a specific goal of tobacco use reduction or on reducing obesity. ~~By February 15, 2013, the commissioner shall report to the chairs of the health and human services committee on progress toward meeting the goals of the program as outlined in Minnesota Statutes, section 145.986, and estimate the dollar~~

~~value of the reduced health care costs for both public and private payers.~~

~~(b) By February 15, 2012, the commissioner shall develop a plan to implement evidence-based strategies from the statewide health improvement program as part of hospital community benefit programs and health maintenance organizations collaboration plans. The implementation plan shall include an advisory board to determine priority needs for health improvement in reducing obesity and tobacco use in Minnesota and to review and approve hospital community benefit activities reported under Minnesota Statutes, section 144.699, and health maintenance organizations collaboration plans in Minnesota Statutes, section 62Q.075. The commissioner shall consult with hospital and health maintenance organizations in creating and implementing the plan. The plan described in this paragraph shall be implemented by July 1, 2012.~~

~~(c) The commissioners of Minnesota management and budget, human services, and health shall include in each forecast beginning February of 2013 a report that identifies an estimated dollar value of the health care savings in the state health care programs that are directly attributable to the strategies funded from the statewide health improvement program. The report shall include a description of methodologies and assumptions used to calculate the estimate.~~

Funding Usage. Up to 75 percent of the fiscal year 2012 appropriation for local public health grants may be used to fund calendar year 2011 allocations for this program and up to 75 percent of the fiscal year 2013 appropriation may be used for calendar year 2012 allocations. The fiscal year 2014 base shall be increased by $5,193,000.

Base Level Adjustment. The general fund base is increased by $5,188,000 in fiscal year 2014 and decreased by $5,000 in 2015.

Sec. 2. Minnesota Statutes 2010, section 62U.04, subdivision 1, is amended to read:

Subdivision 1. **Development of tools to improve costs and quality outcomes.** The commissioner of health shall develop a plan to create transparent prices, encourage greater provider innovation and collaboration across points on the health continuum in cost-effective, high-quality care delivery, reduce the administrative burden on providers and health plans associated with submitting and processing claims, and provide comparative information to consumers on variation in health care cost and quality across providers. ~~The development must be complete by January 1, 2010.~~

Sec. 3. Minnesota Statutes 2010, section 62U.04, subdivision 2, is amended to read:

Subd. 2. **Calculation of health care costs and quality.** The commissioner of health shall develop a uniform method of calculating providers' relative cost of care, defined as a measure of health care spending including resource use and unit prices, and relative quality of care. In developing this method, the commissioner must address the following issues:

(1) provider attribution of costs and quality;

(2) appropriate adjustment for outlier or catastrophic cases;

(3) appropriate risk adjustment to reflect differences in the demographics and health status across provider patient populations, using generally accepted and transparent risk adjustment methodologies and case mix adjustment;

(4) specific types of providers that should be included in the calculation;

(5) specific types of services that should be included in the calculation;

(6) appropriate adjustment for variation in payment rates;

(7) the appropriate provider level for analysis;

(8) payer mix adjustments, including variation across providers in the percentage of revenue received from government programs; and

(9) other factors that the commissioner ~~determines~~ and the advisory committee, established under subdivision 3, determine are needed to ensure validity and comparability of the analysis.

Sec. 4. Minnesota Statutes 2011 Supplement, section 62U.04, subdivision 3, is amended to read:

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

(b) The commissioner shall establish an advisory committee comprised of representatives of health care providers, health plan companies, consumers, state agencies, employers, academic researchers, and organizations that work to improve health care quality in Minnesota. The advisory committee shall meet no fewer than three times per year. The commissioner shall consult with the advisory committee in developing

and administering the peer grouping system, including but not limited to the following activities:

(1) establishing peer groups;

(2) selecting quality measures;

(3) recommending thresholds for completeness of data and statistical significance for the purposes of public release of provider peer grouping results;

(4) considering whether adjustments are necessary for facilities that provide medical education, level 1 trauma services, neonatal intensive care, or inpatient psychiatric care;

(5) recommending inclusion or exclusion of other costs; and

(6) adopting patient attribution and quality and cost-scoring methodologies.

Subd. 3a. **Provider peer grouping; dissemination of data to providers.** ~~(b) By no later than October 15, 2010,~~ (a) The commissioner shall disseminate information to providers on their total cost of care, total resource use, total quality of care, and the total care results of the grouping developed under ~~this~~ subdivision 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner the accuracy and representativeness of any analyses or reports and submit comments to the commissioner or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have ~~30~~ 60 days to review the data for accuracy and initiate an appeal as specified in ~~paragraph (d)~~ subdivision 3b.

~~(c) By no later than January 1, 2011,~~ (b) The commissioner shall disseminate information to providers on their condition-specific cost of care, condition-specific resource use, condition-specific quality of care, and the condition-specific results of the grouping developed under ~~this~~ subdivision 3 in comparison to an appropriate peer group. Data used for this analysis must be the most recent data available. Any analyses or reports that identify providers may only be published after the provider has been provided the opportunity by the commissioner to review the underlying data in order to verify, consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner the accuracy and representativeness of any analyses or reports and submit comments to the commissioner or initiate an appeal under subdivision 3b. ~~Providers may~~ Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have ~~30~~ 60 days to review the data for accuracy and initiate an appeal as specified in ~~paragraph (d)~~ subdivision 3b.

Subd. 3b. **Provider peer grouping; appeals process.** ~~(d)~~ The commissioner shall establish ~~an appeals~~ a process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports or errors in the application of standards or methodology established by the commissioner in consultation with the advisory committee. When a provider ~~appeals the accuracy of the data used to calculate the peer grouping system results~~ submits an appeal, the provider shall:

(1) clearly indicate the reason ~~they believe the data used to calculate the peer group system results are not accurate~~ or reasons for the appeal;

(2) provide any evidence ~~and~~, calculations, or documentation to support the reason ~~that data was not accurate~~ for the appeal; and

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

The commissioner shall cooperate with the provider during the data review period specified in subdivisions 3a and 3c by giving the provider information necessary for the preparation of an appeal.

If a provider does not meet the requirements of this ~~paragraph~~ subdivision, a provider's appeal shall be considered withdrawn. The commissioner shall not publish peer grouping results for a ~~specific~~ provider ~~under paragraph (e) or (f) while that provider has an unresolved appeal~~ until the appeal has been resolved.

Subd. 3c. **Provider peer grouping; publication of information for the public.** ~~(e) Beginning January 1, 2011, the commissioner shall, no less than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.~~ (a) The commissioner may publicly release summary data related to the peer grouping system as long as the data do not contain information or descriptions from which the identity of individual hospitals, clinics, or other providers may be discerned.

~~(f) Beginning March 30, 2011, the commissioner shall no less than annually publish information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis.~~ (b) The commissioner may publicly release analyses or results related to the peer grouping system that identify hospitals, clinics, or other providers only if the following criteria are met:

(1) the results, data, and summaries, including any graphical depictions of provider performance, have been distributed to providers at least 120 days prior to publication;

(2) the commissioner has provided an opportunity for providers to verify and review data for which the provider is the subject consistent with the recommendations developed pursuant to subdivision 3c, paragraph (d), and adopted by the commissioner;

(3) the results meet thresholds of validity, reliability, statistical significance, representativeness, and other standards that reflect the recommendations of the advisory committee, established under subdivision 3; and

(4) any public report or other usage of the analyses, report, or data used by the state clearly notifies consumers about how to use and interpret the results, including any limitations of the data and analysis.

~~(g)~~ (c) After publishing the first public report, the commissioner shall, no less frequently than annually, publish information on providers' total cost, total resource use, total quality, and the results of the total care portion of the peer grouping process, as well as information on providers' condition-specific cost, condition-specific resource use, and condition-specific quality, and the results of the condition-specific portion of the peer grouping process. The results that are published must be on a risk-adjusted basis, including case mix adjustments.

(d) The commissioner shall convene a work group comprised of representatives of physician clinics, hospitals, their respective statewide associations, and other relevant stakeholder organizations to make recommendations on data to be made available to hospitals and physician clinics to allow for verification of the accuracy and representativeness of the provider peer grouping results.

Subd. 3d. **Provider peer grouping; standards for dissemination and publication.** (a) Prior to disseminating data to providers under ~~paragraph (b) or (c)~~ subdivision 3a or publishing information under ~~paragraph (e) or (f)~~ subdivision 3c, the commissioner, in consultation with the advisory committee, shall ensure the scientific and statistical validity and reliability of the results according to the standards described in paragraph ~~(h)~~ (b). If additional time is needed to establish the scientific validity, statistical significance, and reliability of the results, the commissioner may delay the dissemination of data to providers under ~~paragraph (b) or (c)~~ subdivision 3a, or the publication of information under ~~paragraph (e) or (f)~~ subdivision 3c. ~~If the delay is more than 60 days, the commissioner shall report in writing to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance the following information:~~

~~(1) the reason for the delay;~~

~~(2) the actions being taken to resolve the delay and establish the scientific validity and reliability of the results; and~~

~~(3) the new dates by which the results shall be disseminated.~~

~~If there is a delay under this paragraph,~~ The commissioner must disseminate the information to providers under ~~paragraph (b) or (c)~~ subdivision 3a at least ~~90~~ 120 days before publishing results under ~~paragraph (e) or (f)~~ subdivision 3c.

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

(1) use of the best available evidence, research, and methodologies; and

(2) establishment of ~~an~~ explicit minimum reliability ~~threshold~~ thresholds for both quality and costs developed in collaboration with the subjects of the data and the users of the data, at a level not below nationally accepted standards where such standards exist.

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

Sec. 5. Minnesota Statutes 2010, section 62U.04, subdivision 4, is amended to read:

Subd. 4. **Encounter data.** (a) Beginning July 1, 2009, and every six months thereafter, all health plan companies and third-party administrators shall submit encounter data 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; 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) ~~for the purpose of carrying out its responsibilities in this section, and must maintain the data that it receives according to the provisions of this section.~~ to carry out its 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.

Sec. 6. Minnesota Statutes 2010, section 62U.04, subdivision 5, is amended to read:

Subd. 5. **Pricing data.** (a) Beginning July 1, 2009, and annually on January 1 thereafter, all health plan companies and third-party administrators shall submit 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. 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 ~~for the purpose of carrying out its responsibilities under this section~~ to carry out its 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. 7. Minnesota Statutes 2011 Supplement, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** ~~(a)~~ For product renewals or for new products that are offered~~, after 12 months have elapsed from publication by the commissioner of the information in subdivision 3, paragraph (c)~~:

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

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

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

(4) health plan companies that issue health plans in the individual market or the small employer market ~~must~~ may offer at least one health plan that uses the information developed under ~~subdivision 3~~ subdivisions 3 to 3d to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

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

Sec. 8. Minnesota Statutes 2010, section 256B.0754, subdivision 2, is amended to read:

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

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

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

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

Sec. 9. **EFFECTIVE DATE.**

Sections 2 to 8 are effective July 1, 2012, and apply to all information provided or released to the public or to health care providers, pursuant to Minnesota Statutes, section 62U.04, on or after that date. Section 4 shall be implemented by the commissioner of health within available resources.

Presented to the governor April 3, 2012

Signed by the governor April 5, 2012, 03:18 p.m.