CHAPTER 62U
QUALITY OF HEALTH CARE SERVICES; TAX CREDIT

62U.01 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Basket or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health unless otherwise specified.

Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement or prevention of decline in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 6. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 8. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4. For the purposes of this chapter, health plan company shall include county-based purchasing arrangements authorized under section 256B.692.

Subd. 9. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 10. **Provider or health care provider.** "Provider" or "health care provider" means a health care provider as defined in section 62J.03, subdivision 8.

Subd. 11. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services that are covered by the enrollee's contract, but shall look to the health plan company for the payment for covered services, to the extent they are covered.

Subd. 12. **State health care program.** "State health care program" means the medical assistance, MinnesotaCare, and general assistance medical care programs.

Subd. 13. **Third-party administrator.** "Third-party administrator" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

History: *2008 c 358 art 4 s 4; 2009 c 159 s 4*

62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.

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

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

(b) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations.

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

Subd. 3. **Quality transparency.** 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. 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.

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1 to 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, consumers, employers or other health care purchasers, and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 5. **Implementation.** (a) By January 1, 2010, health plan companies shall use the standardized quality measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

(b) By July 1, 2010, the commissioner of management and budget shall implement this incentive payment system for all participants in the state employee group insurance program.

History: *2008 c 358 art 4 s 5; 2009 c 101 art 2 s 109*

62U.03 PAYMENT RESTRUCTURING; CARE COORDINATION PAYMENTS.

(a) By January 1, 2010, health plan companies shall include health care homes in their provider networks and by July 1, 2010, shall pay a care coordination fee for their members who choose to enroll in health care homes certified by the commissioners of health and human services under section 256B.0751. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0753. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes. Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.

(b) By July 1, 2010, the commissioner of management and budget shall implement the care coordination payments for participants in the state employee group insurance program. The commissioner of management and budget may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.

History: *2008 c 358 art 4 s 6; 2009 c 101 art 2 s 109*

62U.04 PAYMENT REFORM; HEALTH CARE COSTS; QUALITY OUTCOMES.

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.

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 and the advisory committee, established under subdivision 3, determine are needed to ensure validity and comparability of the analysis.

Subd. 3. **Provider peer grouping; system development; advisory committee.** (a) The commissioner shall develop a peer grouping system for providers that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. 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.** (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 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. Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have 60 days to review the data for accuracy and initiate an appeal as specified in subdivision 3b.

(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 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. Upon request, providers shall be given any data for which they are the subject of the data. The provider shall have 60 days to review the data for accuracy and initiate an appeal as specified in subdivision 3b.

Subd. 3b. **Provider peer grouping; appeals process.** The commissioner shall establish 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 submits an appeal, the provider shall:

(1) clearly indicate the reason or reasons for the appeal;

(2) provide any evidence, calculations, or documentation to support the reason 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 subdivision, a provider's appeal shall be considered withdrawn. The commissioner shall not publish peer grouping results for a provider until the appeal has been resolved.

Subd. 3c. **Provider peer grouping; publication of information for the public.** (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.

(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, reports, or data used by the state clearly notifies consumers about how to use and interpret the results, including any limitations of the data and analyses.

(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 subdivision 3a or publishing information under 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 (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 subdivision 3a, or the publication of information under subdivision 3c.

The commissioner must disseminate the information to providers under subdivision 3a at least 120 days before publishing results under subdivision 3c.

(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 explicit minimum reliability 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.

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) 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.

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 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.

Subd. 6. **Contracting.** The commissioner may contract with a private entity or consortium of entities to develop the standards. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, health plan companies, hospitals, consumers, employers or other health care purchasers, and state government. The entity or consortium must ensure that the representatives

of stakeholder groups in the aggregate reflect all geographic areas of the state. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Subd. 7. **Consumer engagement.** The commissioner of health shall convene a work group to develop strategies for engaging consumers in understanding the importance of health care cost and quality, specifically as it relates to health care outcomes, consumer out-of-pocket costs, and variations in health care cost and quality across providers. The work group shall develop strategies to assist consumers in becoming advocates for higher value health care and a more efficient, effective health care system. The work group shall make recommendations to the commissioner and the legislature by January 1, 2010, and shall identify specific action steps needed to achieve the recommendations.

Subd. 8. **Provider innovation to reduce health care costs and improve quality.** (a) Nothing in this section shall prohibit group purchasers and health care providers, upon mutual agreement, from entering into arrangements that establish package prices for a comprehensive set of services or separately for the cost of care for specific health conditions in addition to the baskets of care established in section 62U.05, in order to give providers the flexibility to innovate on ways to reduce health care costs while improving overall quality of care and health outcomes.

(b) The commissioner of health may convene working groups of private sector payers and health care providers to discuss and develop new strategies for reforming health care payment systems to promote innovative care delivery that reduces health care costs and improves quality.

Subd. 9. **Uses of information.** For product renewals or for new products that are offered:

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

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

(3) health plan companies may use the information and methods developed under 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 may offer at least one health plan that uses the information developed under 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.

History: *2008 c 358 art 4 s 7; 2009 c 101 art 2 s 109; 2010 c 344 s 1,2; 1Sp2011 c 9 art 6 s 15,16; 2012 c 164 s 2-7*

62U.05 PROVIDER PRICING FOR BASKETS OF CARE.

Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the commissioner shall also consider the prevalence of the health

conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care must incorporate a patient-directed, decision-making support model.

Subd. 2. **Package prices.** (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. **Quality measurements for baskets of care.** (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

History: *2008 c 358 art 4 s 8*

62U.06 COORDINATION; LEGISLATIVE OVERSIGHT.

Subdivision 1. **Coordination.** In carrying out the responsibilities of this chapter, the commissioner of health shall ensure that the activities and data collection are implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

Subd. 2. **Legislative oversight.** Beginning January 15, 2009, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter and sections 256B.0751 to 256B.0754.

Subd. 3. **Rulemaking.** For purposes of this chapter, the commissioner may use the expedited rulemaking process under section 14.389.

History: *2008 c 358 art 4 s 9; 1Sp2011 c 9 art 6 s 17*

62U.07 SECTION 125 PLANS.

Subdivision 1. **Definitions.** For purposes of this section, the following terms have the meanings given them.

(a) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(b) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on the employed person or persons.

(c) "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health coverage premiums with pretax dollars.

(d) "Small employer" means an employer with two to 50 employees.

Subd. 2. **Section 125 Plan requirement.** (a) Effective July 1, 2009, all employers with 11 or more current full-time equivalent employees in this state shall establish and maintain a Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

(1) employers that offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage;

(2) employers that provide self-insurance as defined in section 62E.02; or

(3) employers that have no employees who are eligible to participate in a Section 125 Plan.

(b) Notwithstanding paragraph (a), an employer may opt out of the requirement to establish a Section 125 Plan by sending a form to the commissioner of commerce. The commissioner of commerce shall create a check-box form for employers to opt out. The form must contain a check box indicating the employer is choosing to opt out and a check box indicating that the employer certifies they have received education and information on the advantages of Section 125 Plans. The commissioner of commerce shall make the form available through their Web site by April 1, 2009.

Subd. 3. **Employer requirements.** (a) Employers that do not offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage and are required to offer or choose to offer a Section 125 Plan shall:

(1) allow employees to purchase an individual market health plan for themselves and their dependents;

(2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;

(3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan; and

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Subd. 4. **Section 125 Plan employer incentives.** (a) The commissioner of employment and economic development shall award grants to eligible small employers that establish Section 125 Plans.

(b) In order to be eligible for a grant, a small employer must:

(1) not have offered health insurance to employees through a group health insurance plan as defined in section 62A.10 or through a self-insured plan as defined in section 62E.02 in the 12 months prior to applying for grant funding under this section;

(2) have established a Section 125 Plan within 90 days prior to applying for grant funding under this section, and must not have offered a Section 125 Plan to employees for at least a nine-month period prior to the establishment of the Section 125 Plan under this section; and

(3) certify to the commissioner that the employer has established a Section 125 Plan and meets the requirements of subdivision 3.

(c) The amount of the grant awarded to a small employer under this section shall be $350.

History: *2008 c 358 art 4 s 10*

62U.071 [Repealed, 2009 c 3 s 2]

62U.08 ESSENTIAL BENEFIT SET.

Subdivision 1. **Work group created.** The commissioner of health shall convene a work group to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. The work group shall include representatives of health care providers, health plans, state agencies, and employers. Members of the work group must have expertise in standards for evidence-based care, benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The work group must meet at least once per year and at other times as necessary to make recommendations to the commissioner on updating the benefit set as necessary to ensure that the benefit set continues to be safe, effective, and scientifically based.

Subd. 2. **Duties.** By October 15, 2009, the work group shall develop and submit to the commissioner an initial essential benefit set and design that includes coverage for a broad range of services, is based on scientific evidence that services are clinically effective and cost-effective, and provides lower enrollee cost sharing for services that have been determined to be cost-effective. The benefit set must include necessary evidence-based health care services, procedures, diagnostic tests, and technologies that are scientifically proven to be both clinically effective and cost-effective. In developing its recommendations, the work group may consult with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards.

Subd. 3. **Report.** By January 15, 2010, the commissioner shall report the recommendations of the work group to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care policy and finance.

History: *2008 c 358 art 4 s 11*

62U.09 HEALTH CARE REFORM REVIEW COUNCIL.

Subdivision 1. **Establishment.** The Health Care Reform Review Council is established for the purpose of periodically reviewing the progress of implementation of this chapter and sections 256B.0751 to 256B.0754.

Subd. 2. **Members.** (a) The Health Care Reform Review Council shall consist of 16 members who are appointed as follows:

(1) two members appointed by the Minnesota Medical Association, at least one of whom must represent rural physicians;

(2) one member appointed by the Minnesota Nurses Association;

(3) two members appointed by the Minnesota Hospital Association, at least one of whom must be a rural hospital administrator;

(4) one member appointed by the Minnesota Academy of Physician Assistants;

(5) one member appointed by the Minnesota Business Partnership;

(6) one member appointed by the Minnesota Chamber of Commerce;

(7) one member appointed by the SEIU Minnesota State Council;

(8) one member appointed by the AFL-CIO;

(9) one member appointed by the Minnesota Council of Health Plans;

(10) one member appointed by the Smart Buy Alliance;

(11) one member appointed by the Minnesota Medical Group Management Association;

(12) one consumer member appointed by AARP Minnesota;

(13) one member appointed by the Minnesota Psychological Association; and

(14) one member appointed by the Minnesota Chiropractic Association.

(b) If a member is no longer able or eligible to participate, a new member shall be appointed by the entity that appointed the outgoing member.

Subd. 3. **Operations of council.** (a) The commissioner of health shall convene the first meeting of the council on or before January 15, 2009, following the initial appointment of the members and the advisory council must meet at least quarterly thereafter.

(b) The council is governed by section 15.059, except that members shall not receive per diems and the council does not expire.

History: *2008 c 358 art 4 s 12; 2009 c 159 s 5*

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

Subdivision 1. **Health care access fund transfer.** On June 30, 2009, the commissioner of management and budget shall transfer $50,000,000 from the health care access fund to the general fund.

Subd. 2. **Projected spending baseline.** (a) By June 1, 2009, the commissioner of health shall calculate the annual projected total private and public health care spending for residents of this state and establish a health care spending baseline, beginning for calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Centers for Medicare and Medicaid Services forecast for total growth in national health care expenditures

and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations for the adjustments needed to specifically reflect projected spending for residents of this state.

(c) The commissioner may adjust the projected baseline as necessary to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare and long-term care spending must not be included in the calculations required under this section.

Subd. 3. **Actual spending and savings determination.** By June 1, 2010, and each June 1 thereafter until June 1, 2020, the commissioner of health shall determine the actual total private and public health care spending for residents of this state for the calendar year two years before the current calendar year, based on data collected under chapter 62J, and shall determine the difference between the projected spending, as determined under subdivision 2, and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner shall determine, based on the proportion of spending for state-administered health care programs to total private and public health care spending for the calendar year two years before the current calendar year, the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

Subd. 4. **Repayment of transfer.** When accumulated savings accruing to state-administered health care programs, as calculated under subdivision 3, meet or exceed $50,000,000, the commissioner of health shall certify that event to the commissioner of management and budget. In the next fiscal year following the certification, the commissioner of management and budget shall transfer $50,000,000 from the general fund to the health care access fund. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

Subd. 5. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Public health care spending" means spending for a state-administered health care program.

(c) "State-administered health care program" means medical assistance, MinnesotaCare, general assistance medical care, and the state employee group insurance program.

History: *2008 c 363 art 17 s 1; 2009 c 101 art 2 s 109*

62U.15 ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.

Subdivision 1. **Data from providers.** (a) By July 1, 2012, the commissioner shall review currently available quality measures and make recommendations for future measurement aimed at improving assessment and care related to Alzheimer's disease and other dementia diagnoses, including improved rates and results of cognitive screening, rates of Alzheimer's and other dementia diagnoses, and prescribed care and treatment plans.

(b) The commissioner may contract with a private entity to complete the requirements in this subdivision. If the commissioner contracts with a private entity already under contract through section 62U.02, then the commissioner may use a sole source contract and is exempt from competitive procurement processes.

Subd. 2. **Learning collaborative.** By July 1, 2012, the commissioner shall develop a health care home learning collaborative curriculum that includes screening and education on best practices regarding identification and management of Alzheimer's and other dementia patients under section 256B.0751, subdivision 5, for providers, clinics, care coordinators, clinic administrators, patient partners and families, and community resources including public health.

Subd. 3. **Comparison data.** The commissioner, with the commissioner of human services, the Minnesota Board on Aging, and other appropriate state offices, shall jointly review existing and forthcoming literature in order to estimate differences in the outcomes and costs of current practices for caring for those with Alzheimer's disease and other dementias, compared to the outcomes and costs resulting from:

(1) earlier identification of Alzheimer's and other dementias;

(2) improved support of family caregivers; and

(3) improved collaboration between medical care management and community-based supports.

Subd. 4. **Reporting.** By January 15, 2013, the commissioner must report to the legislature on progress toward establishment and collection of quality measures required under this section.

History: *1Sp2011 c 9 art 2 s 4*