State of Minnesota

HOUSE OF REPRESENTATIVES

NINETIETH SESSION

H. F. No. 1414

02/20/2017 Authored by Hamilton, Albright, Schultz and Zerwas
The bill was read for the first time and referred to the Committee on Health and Human Services Reform
03/08/2017 Adoption of Report: Amended and re-referred to the Committee on Health and Human Services Finance

A bill for an act

relating to health; requiring commissioner of human services to establish demonstration projects for complex patient populations; establishing a fee schedule for providers serving managed care enrollees; requiring a final report on new payment methodologies; establishing alternative performance measures; authorizing commissioner of health to award health information technology grants; modifying requirements governing measures to assess health care quality and quality incentive payments to providers; appropriating money; amending Minnesota Statutes 2016, sections 62J.496, subdivisions 1, 2, by adding a subdivision; 62U.02, subdivisions 1, 2, 3, 4; 256B.072; 256B.0755, by adding a subdivision; 256B.69, by adding a subdivision; Laws 2015, chapter 71, article 11, section 63.

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

ARTICLE 1

PAYMENT REFORM PILOT PROJECTS

Section 1. Minnesota Statutes 2016, section 256B.0755, is amended by adding a subdivision to read:

Subd. 8. **Demonstration projects for complex patient populations.** (a) The commissioner of human services shall establish special demonstration projects for care networks that serve patient populations that experience significantly poorer health, higher risks of chronic disease, and poor quality and outcomes of care relative to the general population due to social, cultural, and economic risk factors affecting population health and the delivery of care. These factors include but are not limited to poverty, homelessness, neighborhood or region of residence, mental health or substance use disorder, transportation barriers, and racial or cultural barriers.

(b) To be eligible to be served by the pilot project, an individual must:

(1) be eligible for medical assistance under section 256B.055 or MinnesotaCare under chapter 256L;

(2) reside in the service area of the care network;

(3) have a combination of multiple risk factors identified by the care network and approved by the commissioner; and

(4) agree to participate in the pilot project. The commissioner may identify an individual who is potentially eligible to be enrolled in the pilot project based on zip code or other geographic designation, medical diagnosis, utilization history, or other factors that indicate whether an individual would benefit from participation in the pilot project.

(c) Pilot projects may be established by care networks made up of multiple providers, or individual providers with care coordination agreements with other providers, who can provide integrated, coordinated services to patients. To participate in the demonstration project, a care network:

(1) must have a patient caseload of which at least … percent of patients are enrolled in medical assistance or MinnesotaCare, or are uninsured;

(2) serve a geographic area whose population experiences substantially poorer overall health compared to the overall Minnesota population;

(3) have lower quality-of-care scores under some traditional quality measures due to the economic, behavioral health, cultural and geographic factors of the patients served rather than the clinical expertise of the providers in the care network; and

(4) serve a population whose utilization history indicates an opportunity to improve health outcomes and reduce total cost of care through better patient engagement, coordination of care, and the provision of specialized services to address nonclinical risk factors and barriers to access.

(d) The commissioner shall waive or modify conditions and requirements for integrated health partnerships under this section that may be a barrier to testing new care delivery models that are tailored to high-risk, complex populations, as follows:

(1) quality of care and patient satisfaction standards must be risk-adjusted to reflect economic, behavioral health, cultural, geographic, or other nonclinical risk factors of the patients served;

(2) the commissioner shall pay a monthly care coordination fee for each enrollee that is in addition to any other payments, gain-sharing, or health care home payments that would otherwise be received;

(3) patient attribution to the care network shall be based on the patients who meet the criteria identified in this section who have agreed to participate in the pilot project;

(4) requirements establishing a minimum number of persons to be eligible to participate in the integrated health network do not apply; and

(5) the commissioner shall waive or modify other integrated health network requirements that may discourage participation by rural, independent, community-based, and safety net providers.

(e) The commissioner, in consultation with the commissioner of health, may authorize care networks to test workforce models that will improve health outcomes or reduce health care costs. The commissioner may waive enrollment, credentialing, or reimbursement conditions or requirements for new or emerging categories of health care professionals and may establish or modify payment methods to encourage the use of new or emerging categories of health care professionals to improve health outcomes or reduce costs.

(f) An existing integrated health partnership operating under this section is eligible to participate in the pilot project while continuing as an integrated health partnership, and qualifies for the exceptions in paragraph (e). All pilot projects authorized under this subdivision are eligible to receive the information and data that are available to integrated health networks.

(g) The commissioners of health and human services, in consultation with care networks and organizations with expertise in serving the patients identified in this subdivision, shall test new methods of measuring provider performance and providing payment incentives to improve health outcomes and reduce administrative burdens for providers and state agencies. The new payment incentives, performance measures must:

(1) pay providers adequately for patient engagement, health improvement, and care coordination services for high-risk, complex populations;

(2) ensure that providers use the additional payments made available under this subdivision to reduce the total costs of health care for patients by reducing unnecessary utilization of hospital services, emergency rooms, and high-cost specialty services and prescription drugs; and

(3) establish payment methods and set payment amounts based in part on patient complexity related to poverty, homelessness, mental health or substance abuse, rural isolation, transportation barriers, and language or cultural barriers. Total payment may reflect payments for new types of cost-effective services or health professionals, higher rates for existing cost-effective covered services and health professionals, and special add-on payment amounts that increase existing payment rates based on the nonclinical factors contributing to the complexity of the patients served.

(h) A health care provider participating in a pilot project under this subdivision remains eligible to receive any other payments authorized by federal or state law, rule, or policy, unless the provider and commissioner have mutually agreed to an alternative payment method intended to replace an existing payment method. This includes but is not limited to base payment rates, add-on payments, critical access payments, disproportionate share payments, or other special rates. The commissioner shall also require any managed care organization under contract with the commissioner to deliver services to medical assistance and MinnesotaCare enrollees to continue to make payments to a provider participating in a pilot project under this section for services provided to medical assistance and MinnesotaCare enrollees.

ARTICLE 2

ADEQUACY OF MANAGED CARE PAYMENTS

Section 1. Minnesota Statutes 2016, section 256B.69, is amended by adding a subdivision to read:

Subd. 36. **Payment rates.** The commissioner shall develop a minimum provider payment fee schedule for managed care plans and county-based purchasing plans for use in reimbursing health care providers for services delivered to medical assistance and MinnesotaCare enrollees. A managed care or county-based purchasing plan must pay health care providers at least the minimum amount specified in the fee schedule. The minimum amount specified shall be 110 percent of the base payment amount that applies to services provided to persons not enrolled in a managed care or county-based purchasing plan. The base payment amount must include all applicable payment increases, add-on or supplemental payments, disproportionate share payments, critical access payments, care coordination payments, and gain-sharing payments, and payment amounts determined under any applicable prospective or alternative payment method. Managed care and county-based purchasing plans must submit documentation of compliance with this requirement to the commissioner, in the form and manner specified by the commissioner. For purposes of this subdivision,

"health care provider" means a vendor of medical care as defined in section 256B.02, subdivision 7.

Sec. 2. Laws 2015, chapter 71, article 11, section 63, is amended to read:

Sec. 63. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

(a) The commissioner of human services shall develop a methodology to pay a higher payment rate for health care providers and services that takes into consideration the higher cost, complexity, and resources needed to serve patients and populations who experience the greatest health disparities in order to achieve the same health and quality outcomes that are achieved for other patients and populations. In developing the methodology, the commissioner shall take into consideration all existing payment methods and rates, including add-on or enhanced rates paid to providers serving high concentrations of low-income patients or populations or providing access in underserved regions or populations. The new methodology must not result in a net decrease in total payment from all sources for those providers who qualify for additional add-on payments or enhanced payments, including, but not limited to, critical access dental, community clinic add-ons, federally qualified health centers payment rates, and disproportionate share payments. The commissioner shall develop the methodology in consultation with affected stakeholders, including communities impacted by health disparities, using culturally appropriate methods of community engagement. The proposed methodology must include recommendations for how the methodology could be incorporated into payment methods used in both fee-for-service and managed care plans.

(b) The commissioner shall submit a report on the analysis and provide options for new payment methodologies that incorporate health disparities to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by February 1, 2016. The scope of the report and the development work described in paragraph (a) is limited to data currently available to the Department of Human Services; analyses of the data for reliability and completeness; analyses of how these data relate to health disparities, outcomes, and expenditures; and options for incorporating these data or measures into a payment methodology.

(c) The commissioner shall submit a final report, implementation plan, and implementation budget to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance by December 1, 2017.

ARTICLE 3

REFORMS TO PROVIDER PAYMENTS AND QUALITY STANDARDS

Section 1. Minnesota Statutes 2016, section 62U.02, subdivision 1, is amended to read:

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. Quality measures must be based on medical evidence and be developed through a process in which providers and consumers 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)~~ (3) place a priority on measures of health care outcomes and health improvement, rather than process measures, wherever possible; and

~~(5)~~ (4) incorporate measures for primary care, including health risk assessments and preventive and health improvement services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner.

(b) Effective July 1, 2016, the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available. On or after January 1, 2018, the commissioner ~~may require measures to be stratified by~~ shall stratify all measures by a population health risk index factor that accounts for a combination of factors outside the control of health care providers that affect patient health and provider performance on quality measures. Population health risk factors to be considered in developing the index shall include poverty, neighborhood or region of residence, homelessness, co-occurring mental health and substance use disorders, and other sociodemographic factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the

methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. ~~The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity.~~ Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

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

Sec. 2. Minnesota Statutes 2016, section 62U.02, subdivision 2, is amended to read:

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 factor out nonclinical factors that affect quality measures scores and to reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors, including those population health risk factors specified in subdivision 1, paragraph (b).

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

Sec. 3. Minnesota Statutes 2016, section 62U.02, subdivision 3, is amended to read:

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

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph (b), that are correlated with health disparities and have an impact on performance on cost and quality measures. The risk adjustment method may consist of reporting based on one or more of the following: adjustment of scores based on the index established under subdivision 1; an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital; or segmentation of providers based on characteristics of patient populations served. The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

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

Sec. 4. Minnesota Statutes 2016, section 62U.02, subdivision 4, is amended to read:

Subd. 4. **Contracting.** The commissioner may contract with ~~a private entity or consortium of~~ one or more private entities to complete the tasks in subdivisions 1 to 3. ~~The~~ A private entity or consortium must ~~be nonprofit and~~ have governance that includes representatives from the following stakeholder groups: health care providers, including providers serving high concentrations of patients and communities impacted by health disparities; health plan companies; consumers, including consumers representing groups who experience health disparities; 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.

Sec. 5. Minnesota Statutes 2016, section 256B.072, is amended to read:

256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.

Subdivision 1. **Establishment and administration.** (a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may require providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

Subd. 2. **Alternative performance measures.** (a) The commissioner shall develop alternative performance measures for providers who primarily serve patients who:

(1) are uninsured or enrolled in Minnesota health care programs; and

(2) display socioeconomic characteristics associated with poor health outcomes.

The commissioner, beginning July 1, 2018, shall give providers the option to have their performance measured using these alternative measures. The commissioner shall develop and use alternative measures for all provider performance reporting initiatives administered by the commissioner, including but not limited to those initiatives required by this section.

(b) Alternative performance measures:

(1) must account for nonclinical patient characteristics that are correlated with health disparities and have an impact on provider performance on standardized statewide cost and quality measures;

(2) may include new measures appropriate to the patient population served, standardized statewide measures that have been adjusted or modified to account for sociodemographic factors, or a combination of both types of measures; and

(3) must include one or more measures of provider initiatives to improve the health of patients and prevent future chronic disease, in addition to measures related to the quality of care.

(c) The alternative measures must be developed and used for all:

(1) public reporting of provider performance;

(2) provider quality measurement and payment rate determinations under fee-for-service, managed care, and county-based purchasing; and

(3) provider quality measurement and payment rate determinations under value-based purchasing and care coordination arrangements, including but not limited to those initiatives operating under sections 256B.0751, 256B.0753, 256B.0755, 256B.0756, and 256B.0757.

(d) The commissioner shall establish eligibility criteria for providers to participate in the alternative performance measurement system, and a process for providers to voluntarily opt in. The commissioner may require providers to submit any additional information

necessary to determine eligibility for the alternative performance measurement system and to measure provider performance using the alternative measures.

ARTICLE 4

HEALTH INFORMATION TECHNOLOGY GRANTS

Section 1. Minnesota Statutes 2016, section 62J.496, subdivision 1, is amended to read:

Subdivision 1. **Account establishment.** (a) An account is established to:

(1) finance the purchase of certified electronic health records or qualified electronic health records as defined in section 62J.495, subdivision 1a;

(2) enhance the utilization of electronic health record technology, which may include costs associated with upgrading the technology to meet the criteria necessary to be a certified electronic health record or a qualified electronic health record;

(3) train personnel in the use of electronic health record technology; ~~and~~

(4) improve the secure electronic exchange of health information; and

(5) improve the use of health information technology and data analytics to support new health care delivery models and payment models designed to improve health outcomes and reduce the total cost of care.

(b) Amounts deposited in the account, including any grant funds obtained through federal or other sources, loan repayments, and interest earned on the amounts shall be used only for awarding loans or loan guarantees, as a source of reserve and security for leveraged loans, for activities authorized in section 62J.495, ~~subdivision~~ subdivisions 4 and 5, or for the administration of the account.

(c) The commissioner may accept contributions to the account from private sector entities subject to the following provisions:

(1) the contributing entity may not specify the recipient or recipients of any loan issued under this subdivision;

(2) the commissioner shall make public the identity of any private contributor to the loan and grant fund, as well as the amount of the contribution provided;

(3) the commissioner may issue letters of commendation or make other awards that have no financial value to any such entity; and

(4) a contributing entity may not specify that the recipient or recipients of any loan use specific products or services, nor may the contributing entity imply that a contribution is an endorsement of any specific product or service.

(d) The commissioner may use the loan funds to reimburse private sector entities for any contribution made to the loan and grant fund. Reimbursement to private entities may not exceed the principle amount contributed to the loan and grant fund.

(e) The commissioner may use funds deposited in the account to guarantee, or purchase insurance for, a local obligation if the guarantee or purchase would improve credit market access or reduce the interest rate applicable to the obligation involved.

(f) The commissioner may use funds deposited in the account as a source of revenue or security for the payment of principal and interest on revenue or general obligation bonds issued by the state if the proceeds of the sale of the bonds will be deposited into the loan and grant fund.

(g) The commissioner shall not award new loans or loan guarantees after July 1, 2016.

Sec. 2. Minnesota Statutes 2016, section 62J.496, subdivision 2, is amended to read:

Subd. 2. **Eligibility.** (a) "Eligible borrower" or "eligible grantee" means one of the following:

(1) federally qualified health centers;

(2) community clinics, as defined under section 145.9268;

(3) nonprofit or local unit of government hospitals licensed under sections 144.50 to 144.56;

(4) individual or small group physician practices that are focused primarily on primary care;

(5) nursing facilities licensed under sections 144A.01 to 144A.27;

(6) local public health departments as defined in chapter 145A; ~~and~~

(7) community-based mental health, substance use disorder, or dental providers who are not part of a large health system, large health care corporation, or large group practice; and

~~(7)~~ (8) other providers of health or health care services approved by the commissioner for which interoperable electronic health record capability would improve quality of care, patient safety, or community health.

(b) The commissioner shall administer the loan and grant fund to prioritize support and assistance to:

(1) critical access hospitals;

(2) federally qualified health centers;

(3) community-based entities that serve a high proportion of uninsured, underinsured, and medically underserved individuals, regardless of whether such area is urban or rural;

(4) individual or small group practices that are primarily focused on primary care and serve a high proportion of patients who are low income and uninsured, underinsured, or enrolled in medical assistance or MinnesotaCare;

(5) nursing facilities certified to participate in the medical assistance program; and

(6) providers enrolled in the elderly waiver program of customized living or 24-hour customized living of the medical assistance program, if at least half of their annual operating revenue is paid under the medical assistance program.

(c) An eligible applicant must submit a loan application to the commissioner of health on forms prescribed by the commissioner. The application must include, at a minimum:

(1) the amount of the loan requested and a description of the purpose or project for which the loan proceeds will be used;

(2) a quote from a vendor;

(3) a description of the health care entities and other groups participating in the project;

(4) evidence of financial stability and a demonstrated ability to repay the loan; and

(5) a description of how the system to be financed interoperates or plans in the future to interoperate with other health care entities and provider groups located in the same geographical area;

(6) a plan on how the certified electronic health record technology will be maintained and supported over time; and

(7) any other requirements for applications included or developed pursuant to section 3014 of the HITECH Act.

Sec. 3. Minnesota Statutes 2016, section 62J.496, is amended by adding a subdivision to read:

Subd. 5. **Technology grants.** In addition to administering the loan program under this section, the commissioner shall award grants to eligible grantees according to the priorities in subdivision 2, paragraph (b). Grants must be awarded from money appropriated to the commissioner for purposes of this section or from money obtained from other sources as authorized under subdivision 1. Grant funds must be used for the purposes specified in subdivision 1.

APPENDIX
Article locations in H1414-1