# SENATE
## STATE OF MINNESOTA
## NINETIETH SESSION

# S.F. No. 1784

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| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 03/06/2017 | 1066 | Introduction and first reading<br>Referred to Health and Human Services Finance and Policy |


A bill for an act

relating to health care; establishing medical assistance hospital outcomes program and managed care organization outcomes program; proposing coding for new law in Minnesota Statutes, chapter 256B.

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

Section 1. **[256B.90] DEFINITIONS.**

Subdivision 1. **Generally.** For the purposes of this section to section 256B.94, the following terms have the meanings given.

Subd. 2. **Avoidable hospital use.** "Avoidable hospital use" means individually or collectively potentially avoidable admissions, potentially avoidable emergency visits, and potentially avoidable readmissions.

Subd. 3. **Commissioner.** "Commissioner" means the commissioner of human services.

Subd. 4. **Department.** "Department" means the Department of Human Services.

Subd. 5. **Hospital.** "Hospital" means a public or private institution licensed as a hospital under section 144.50 that participates in medical assistance.

Subd. 6. **Managed care organization or MCO.** "Managed care organization" or "MCO" means a licensed managed care organization that the commissioner has contracted to provide, or arrange for, services to medical assistance recipients.

Subd. 7. **Medical assistance.** "Medical assistance" means the state's Medicaid program under title XIX of the Social Security Act and administered according to this chapter.

Subd. 8. **Potentially avoidable admission.** "Potentially avoidable admission" means an admission of an individual to a hospital or long-term care facility that may have reasonably been prevented with adequate access to ambulatory care or health care coordination.

Subd. 9. **Potentially avoidable ancillary service.** "Potentially avoidable ancillary service" means a health care service provided or ordered by a physician or other health care provider to supplement or support the evaluation or treatment of an individual, including a diagnostic test, laboratory test, therapy service, or radiology service, that may not be reasonably necessary for the provision of quality health care or treatment.

Subd. 10. **Potentially avoidable complication.** "Potentially avoidable complication" means a harmful event or negative outcome with respect to an individual, including an infection or surgical complication, that: (1) occurs after the individual's admission to a hospital or long-term care facility; and (2) may have resulted from the care, lack of care, or treatment provided during the hospital or long-term care facility stay rather than from a natural progression of an underlying disease.

Subd. 11. **Potentially avoidable emergency visit.** "Potentially avoidable emergency visit" means treatment of an individual in a hospital emergency room or freestanding emergency medical care facility for a condition that may not require emergency medical attention because the condition could be, or could have been, treated or prevented by a physician or other health care provider in a nonemergency setting.

Subd. 12. **Potentially avoidable event.** "Potentially avoidable event" means a potentially avoidable admission, potentially avoidable ancillary service, potentially avoidable complication, potentially avoidable emergency visit, potentially avoidable readmission, or a combination of those events.

Subd. 13. **Potentially avoidable readmission.** "Potentially avoidable readmission" means a return hospitalization of an individual within a period specified by the commissioner that may have resulted from deficiencies in the care or treatment provided to the individual during a previous hospital stay or from deficiencies in posthospital discharge follow-up. Potentially avoidable readmission does not include a hospital readmission necessitated by the occurrence of unrelated events after the discharge. Potentially avoidable readmission includes the readmission of an individual to a hospital for: (1) the same condition or procedure for which the individual was previously admitted; (2) an infection or other complication resulting from care previously provided; or (3) a condition or procedure that indicates that a surgical intervention performed during a previous admission was unsuccessful in achieving the anticipated outcome.

Sec. 2. **[256B.91] MEDICAL ASSISTANCE OUTCOMES-BASED PAYMENT PROGRAMS.**

Subdivision 1. **Generally.** The commissioner must establish and implement two linked medical assistance outcomes-based payment programs:

(1) a hospital outcomes program under section 256B.92 to provide hospitals with information and incentives to reduce potentially avoidable events; and

(2) an MCO outcomes program under section 256B.93 to provide MCOs with information and incentives to reduce potentially avoidable events.

Subd. 2. **Potentially avoidable event methodology.** (a) The commissioner shall select a methodology for identifying potentially avoidable events and for the costs associated with these events, and for measuring hospital and MCO performance with respect to these events.

(b) The commissioner shall develop definitions for each potentially avoidable event according to the selected methodology.

(c) To the extent possible, the methodology shall be one that has been used by other title XIX programs under the Social Security Act or by commercial payers in health care outcomes performance measurement and in outcome based payment programs. The methodology shall be open, transparent, and available for review by the public.

Subd. 3. **Medical assistance system waste.** (a) The commissioner must conduct a comprehensive analysis of relevant state databases to identify waste in the medical assistance system.

(b) The analysis must identify instances of potentially avoidable events in medical assistance, and the costs associated with these events. The overall estimate of waste must be broken down into actionable categories including but not limited to regions, hospitals, MCOs, physicians, service lines, diagnosis-related groups, medical conditions and procedures, patient characteristics, provider characteristics, and medical assistance program type.

(c) Information collected from this analysis must be utilized in hospital and MCO outcomes programs described in this section.

Sec. 3. **[256B.92] HOSPITAL OUTCOMES PROGRAM.**

Subdivision 1. **Generally.** The hospital outcomes program shall:

(1) target reduction of potentially avoidable readmissions and complications;

(2) apply to all state acute care hospitals participating in medical assistance. Program adjustments may be made for certain types of hospitals; and

(3) be implemented in two phases: performance reporting and outcomes-based financial incentives.

Subd. 2. **Phase 1; performance reporting.** (a) The commissioner shall develop and maintain a reporting system to provide each hospital in Minnesota with regular confidential reports regarding the hospital's performance for potentially avoidable readmissions and potentially avoidable complications.

(b) The commissioner shall:

(1) conduct ongoing analyses of relevant state claims databases to identify instances of potentially avoidable readmissions and potentially avoidable complications, and the expenditures associated with these events;

(2) create or locate state readmission and complications norms;

(3) measure actual-to-expected hospital performance compared to state norms;

(4) compare hospitals with peers using risk adjustment procedures that account for the severity of illness of each hospital's patients;

(5) distribute reports to hospitals to provide actionable information to create policies, contracts, or programs designed to improve target outcomes; and

(6) foster collaboration among hospitals to share best practices.

(c) A hospital may share the information contained in the outcome performance reports with physicians and other health care providers providing services at the hospital to foster coordination and cooperation in the hospital's outcome improvement and waste reduction initiatives.

Subd. 3. **Phase 2; outcomes-based financial incentives.** Twelve months after implementation of performance reporting under subdivision 2, the commissioner must establish financial incentives for a hospital to reduce potentially avoidable readmissions and potentially avoidable complications.

Subd. 4. **Rate adjustment methodology.** (a) The commissioner must adjust the reimbursement that a hospital receives under the All Patients Refined Diagnosis-Related Group inpatient prospective payment system based on the hospital's performance exceeding, or failing to achieve, outcome results based on the rates of potentially avoidable readmissions and potentially avoidable complications.

(b) The rate adjustment methodology must:

(1) apply to each hospital discharge;

(2) determine a hospital-specific potentially avoidable outcome adjustment factor based on the hospital's actual versus expected risk-adjusted performance compared to the state norm;

(3) be based on a retrospective analysis of performance prospectively applied;

(4) include both rewards and penalties; and

(5) be communicated to a hospital in a clear and transparent manner.

Subd. 5. **Amendment of contracts.** The commissioner must amend contracts with participating hospitals as necessary to incorporate the financial incentives established under this section.

Subd. 6. **Budget neutrality.** The hospital outcomes program shall be implemented in a budget-neutral manner for a hospital.

Sec. 4. **[256B.93] MANAGED CARE OUTCOMES PROGRAM.**

Subdivision 1. **Generally.** The MCO outcomes program must:

(1) target reduction of avoidable admissions, readmissions, and emergency visits;

(2) apply to all MCOs participating in medical assistance; and

(3) be implemented in two phases: performance reporting and outcomes-based financial incentives.

Subd. 2. **Phase 1; performance reporting.** (a) The commissioner must develop and maintain a reporting system to provide each MCO with regular confidential reports regarding the MCO's performance for potentially avoidable admissions, potentially avoidable readmissions, and potentially avoidable emergency visits.

(b) The commissioner shall:

(1) conduct ongoing analyses of relevant state claims databases to identify instances of potentially avoidable admissions, potentially avoidable readmissions, and potentially avoidable emergency visits along with expenditures associated with these events;

(2) create or locate state norms for admissions, readmissions, and emergency visits;

(3) measure actual-to-expected MCO performance compared to state norms;

(4) compare MCOs with peers using risk adjustment procedures that account for the chronic illness burden of each plan's enrollees; and

(5) distribute reports to MCOs with actionable information to create policies, contracts, or programs designed to improve target outcomes.

(c) An MCO may share the information contained in the outcome performance reports with its participating providers to foster coordination and cooperation in the MCO's outcome improvement and waste reduction initiatives.

Subd. 3. **Phase 2; outcomes-based financial incentives.** Twelve months after implementation of performance reporting under subdivision 2, the commissioner must establish financial incentives for an MCO to reduce potentially avoidable admissions, potentially avoidable readmissions, and potentially avoidable emergency visits.

Subd. 4. **Capitation rate adjustment.** (a) The commissioner must adjust each MCO's capitation rate based on the MCO's performance exceeding, or failing to achieve, outcome results based on the rates of potentially avoidable readmissions, potentially avoidable admissions, and potentially avoidable emergency visits.

(b) The methodology for determining an MCO's capitation rate adjustment must:

(1) apply to the plan's annual capitation rate;

(2) determine a plan's specific potentially avoidable outcome adjustment factor based on the plan's actual versus expected risk-adjusted performance compared to the state norm;

(3) be based on a retrospective analysis of performance and prospectively applied;

(4) contain both rewards and penalties;

(5) include risk corridors; and

(6) be communicated to an MCO in a clear and transparent manner.

Subd. 5. **Amendment of contracts.** The commissioner must amend contracts with participating MCOs as necessary to incorporate the financial incentives established under this section.