State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 2774

03/06/2014 Authored by Moran
The bill was read for the first time and referred to the Committee on Health and Human Services Policy

A bill for an act

relating to health care; requiring performance data collected by the Department of Health to be collected based on race, ethnicity, language, and other patient characteristics; requiring the Department of Health to develop a risk adjustment methodology; appropriating money; amending Minnesota Statutes 2012, section 62U.02, subdivisions 1, 3.

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

Section 1. Minnesota Statutes 2012, 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. In developing the measures, the commissioner shall, as appropriate, consider national measures that are agreed to or endorsed by national quality groups. 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.;

(6) ensure that data used for measurement are collected or can be sorted by categories of race, ethnicity, language, socioeconomic status, and other relevant patient characteristics that research and data show are correlated with health, access, and quality of care. The categories and data collection methods must be developed in consultation with organizations led by and representing these categories of individuals. Additional sources of data, other than the outcomes and process data submitted by a clinic or hospital under subdivision 3, may be used to attribute patient characteristics to a patient population served by a clinic or hospital, including, but not limited to, census data, geocoded data, and clinic or hospital reports on the demographics and characteristics of their patient population; and

(7) ensure that the measures are risk-adjusted for patient characteristics identified under clause (6) that have an impact on provider quality and cost.

(b) The commissioner shall ensure that the data collected is sufficient to allow for the calculation and reporting of measures by categories of race, ethnicity, language, socioeconomic status, and other relevant variables and patient characteristics for use in identifying and eliminating health disparities.

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

Sec. 2. Minnesota Statutes 2012, section 62U.02, subdivision 3, is amended to read:

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. The risk adjustment system shall take into consideration patient characteristics identified under subdivision 1, paragraph (a), clause (6), that have an impact on performance, quality, and cost measures. 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.

Sec. 3. **HEALTH DISPARITIES REPORTING AND RISK ADJUSTMENT METHODOLOGY.**

(a) The commissioner of health shall conduct analysis, design, testing, and implementation activities needed to develop and implement the new data collection, reporting, and risk-adjustment methods required under Minnesota Statutes, section 62U.02, subdivisions 1, paragraph (a), clauses (6) and (7), and 3. The commissioner may contract with a vendor or vendors as needed to meet the requirements described in paragraph (b).

(b) The commissioner shall:

(1) provide possible options for risk-adjustment methods, including both existing risk-adjustment methods currently in use and proposed methods yet to be developed, with the advantages and disadvantages of each method;

(2) work with other state agencies and stakeholders to evaluate the risk-adjustment options identified under clause (1) and select an option for testing in Minnesota;

(3) develop a work plan for the development, testing, and implementation of the risk-adjustment method to be used in Minnesota for performance; and

(4) undertake data analysis to evaluate options, select an option, and develop and test the methodology selected for implementation.

(c) If the commissioner contracts with a vendor to implement any or all of the requirements under this section, the vendor must have the following qualifications:

(1) knowledge of and experience working with research and data on health disparities and the impact of socioeconomic status and risk factors on health, quality of care, and health care costs;

(2) knowledge of existing and proposed new risk-adjustment methods of provider and health plan quality and performance data based on the socioeconomic risk factors of the patients served; and

(3) the ability to perform data analysis to develop and test risk-adjustment methods that could be used to adjust provider and health plan quality, cost, and performance data to reflect the socioeconomic status and risk factors of the patients or enrollees.

(d) The commissioner shall ensure that any advisory committee or work group convened by the commissioner or by the vendor to provide information, expertise, and advice in the development, testing, and implementation of the risk-adjustment method must include representatives of health care providers and consumer organizations who serve a high proportion of patients or enrollees who are low-income, racially or culturally diverse, or have other socioeconomic risk factors.

Sec. 4. **APPROPRIATION.**

$..... is appropriated from the general fund to the commissioner of health for the fiscal year ending June 30, 2015, for purposes of implementing sections 1 to 3.