

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