# SENATE
## STATE OF MINNESOTA
## EIGHTY-NINTH SESSION

# S.F. No. 501

**(SENATE AUTHORS: WIKLUND, Lourey, Sheran, Rosen and Hayden)**

| DATE | D-PG | OFFICIAL STATUS |
|---|---|---|
| 02/02/2015 | 191 | Introduction and first reading<br>Referred to Health, Human Services and Housing |
| 02/26/2015 | | Comm report: To pass as amended and re-refer to Judiciary |

A bill for an act

relating to health; requiring health care quality measures and payment methods to identify and adjust for health disparities related to race, ethnicity, language, and sociodemographic risk factors; establishing a health equity data plan; appropriating money; amending Minnesota Statutes 2014, sections 62U.02, subdivisions 1, 2, 3, 4; 256B.072.

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

Section 1. Minnesota Statutes 2014, 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 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; and

(6) effective January 1, 2016, be stratified by race, ethnicity, preferred language, and country of origin. On or after January 1, 2017, the commissioner may require measures to be stratified by other sociodemographic factors that are correlated with health disparities and have an impact on performance on quality and cost indicators after completion of voluntary pilot projects. 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.

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

Sec. 2. Minnesota Statutes 2014, 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 reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, and sociodemographic factors.

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

Sec. 3. Minnesota Statutes 2014, 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 January 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph (a), clause (6), 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 an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital.

(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 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. 4. Minnesota Statutes 2014, section 62U.02, subdivision 4, is amended to read:

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, 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 2014, section 256B.072, is amended to read:

**256B.072 PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.**

(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) Effective January 1, 2016, performance measures must be stratified by race, ethnicity, preferred language, and country of origin consistent with section 62U.02, subdivision 1, paragraph (a), clause (6). On or after January 1, 2017, performance measures must be stratified by other sociodemographic factors incorporated into the statewide quality reporting and measurement system by the commissioner of health under section 62U.02, subdivision 1, paragraph (a), clause (6). By January 1, 2017, performance measures must be risk adjusted based on these factors pursuant to section 62U.02, subdivision 3, paragraph (b).

Sec. 6. **HEALTH DISPARITIES PAYMENT ENHANCEMENT.**

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. The commissioner shall submit a report and recommendations to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finances by December 15, 2015, including the proposed methodology for providing a health disparities payment adjustment.

Sec. 7. **APPROPRIATIONS.**

Subdivision 1. **Commissioner of health.** $..... is appropriated for the biennium ending June 30, 2017, from the general fund to the commissioner of health for the following:

(1) the development of the quality incentive payment system specified in Minnesota Statutes, section 62U.02, subdivision 1, paragraph (a), clause (6);

(2) the development of the risk adjustment system specified in Minnesota Statutes, section 62U.02, subdivision 3, paragraph (b); and

(3) community engagement with those communities impacted by health disparities.

Subd. 2. **Commissioner of human services.** $..... is appropriated for the biennium ending June 30, 2017, from the general fund to the commissioner of human services for the modification of provider performance measures under Minnesota Statutes, section 256B.072, paragraph (e), to implement stratification and risk adjustment methods.