SENATE
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S.F. No. 2106

(SENATE AUTHORS: LOUREY, Sheran, Rosen and Nelson)

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03/03/2014	5940	Authors added Sheran; Rosen
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A bill for an act

relating to health; modifying the use of the all-payer claims data; convening a work group to make recommendations on expanded uses of the all-payer claims database; amending Minnesota Statutes 2012, section 62U.04, subdivisions 2, 3, 3b, 3c, 3d, 4, 5, by adding subdivisions; repealing Minnesota Statutes 2012, section 62U.04, subdivision 7.

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

Section 1. Minnesota Statutes 2012, section 62U.04, subdivision 2, is amended to read:

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~~ determines are needed to ensure validity and comparability of the analysis.

Sec. 2. Minnesota Statutes 2012, section 62U.04, subdivision 3, is amended to read:

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.~~

Sec. 3. Minnesota Statutes 2012, section 62U.04, subdivision 3b, is amended to read:

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.

Sec. 4. Minnesota Statutes 2012, section 62U.04, subdivision 3c, is amended to read:

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.~~

Sec. 5. Minnesota Statutes 2012, section 62U.04, subdivision 3d, is amended to read:

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.

Sec. 6. Minnesota Statutes 2012, section 62U.04, subdivision 4, is amended to read:

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)~~ (c) The commissioner or the commissioner's designee shall not publish analyses or reports that identify, or could potentially identify, individual patients.

Sec. 7. Minnesota Statutes 2012, section 62U.04, subdivision 5, is amended to read:

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.

Sec. 8. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:

Subd. 10. **Suspension.** Notwithstanding subdivisions 3 to 3d, the commissioner shall suspend the development and implementation of the provider peer grouping system required under this section.

Sec. 9. Minnesota Statutes 2012, section 62U.04, is amended by adding a subdivision to read:

Subd. 11. **Restricted uses of the all-payer claims data.** (a) The commissioner or the commissioner's designee shall only use the data submitted under subdivisions 4 and 5 for the following purposes:

(1) to evaluate the performance of the health care home program, including the use of aggregate data to measure the impact of health care homes on health care costs, quality, and utilization;

(2) to study, in collaboration with the Reducing Avoidable Readmissions Effectively (RARE) campaign, hospital readmission trends and rates;

(3) to analyze variations in health care costs, quality, and utilization based on geographical areas, delivery models, or populations; and

(4) to evaluate the state innovation model (SIM) testing grant received by the Departments of Health and Human Services, including the analysis of health care cost, quality, and utilization baseline and trend information for targeted populations and communities.

(b) The commissioner may publish the results of the authorized uses identified in paragraph (a) so long as the data released publicly do not contain information or descriptions in which the identity of individual hospitals, clinics, or other providers may be discerned.

Sec. 10. **ALL-PAYER CLAIMS DATABASE WORK GROUP.**

(a) The commissioner of health shall convene a work group to develop a framework for the expanded use of the all-payer claims database established under Minnesota Statutes, section 62U.04. The work group shall develop recommendations based on the following questions:

(1) what should the parameters be for allowable uses of the all-payer claims data collected under Minnesota Statutes, section 62U.04, beyond the uses authorized in Minnesota Statutes, section 62U.04, subdivision 11;

(2) what should be the criteria and processes for evaluating the all-payer claims data requests;

(3) what type of advisory or governing body should guide the release of data from the all-payer claims database;

(4) what type of funding or fee structure would be needed to support the expanded use of all-payer claims data. Should the funding structure be stratified based on the proposed use, type of requesting organization, type or scope of data requested, or other criteria;

(5) what should the mechanisms be by which the data would be released or accessed, including the necessary information technology infrastructure to support the expanded use of the data under different assumptions related to the number of potential requests and manner of access;

(6) what are the appropriate privacy and security protections needed for the expanded use of the all-payer claims database; and

(7) what additional resources might be needed to support the expanded use of the all-payer claims database, including expected resources related to information technology infrastructure, review of proposals, maintenance of data use agreements, staffing an advisory body, or other new efforts.

(b) The commissioner of health shall appoint the members to the work group as follows:

(1) two members recommended by the Minnesota Medical Association;

(2) two members recommended by the Minnesota Hospital Association;

(3) two members recommended by the Minnesota Council of Health Plans;

(4) one member who is a data practices expert from the Department of Administration;

(5) three members appointed by the commissioner who are academic researchers from the University of Minnesota with expertise in claims database analysis; and

(6) three members representing consumers appointed by the commissioner of health.

(c) The commissioner of health shall submit a report on the recommendations of the work group to the chairs and ranking minority members of the legislative committees

and divisions with jurisdiction over health and human services, judiciary, and civil law by February 1, 2015.

Sec. 11. **REPEALER.**

Minnesota Statutes 2012, section 62U.04, subdivision 7, is repealed.

EFFECTIVE DATE. This section is effective the day following final enactment.

62U.04 PAYMENT REFORM; HEALTH CARE COSTS; QUALITY OUTCOMES.

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.