

CHAPTER 62U

HEALTH CARE PAYMENT AND PRICING REFORM

62U.01	DEFINITIONS.	62U.06	COORDINATION; LEGISLATIVE OVERSIGHT.
62U.02	PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.	62U.07	SECTION 125 PLANS.
62U.03	HEALTH CARE HOMES.	62U.08	ESSENTIAL BENEFIT SET.
62U.04	PAYMENT REFORM; HEALTH CARE COSTS; QUALITY OUTCOMES.	62U.10	HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.
62U.05	PROVIDER PRICING FOR BASKETS OF CARE.	62U.15	ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.

62U.01 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of this chapter, the terms defined in this section have the meanings given, unless otherwise specified.

Subd. 2. **Basket or baskets of care.** "Basket" or "baskets of care" means a collection of health care services that are paid separately under a fee-for-service system, but which are ordinarily combined by a provider in delivering a full diagnostic or treatment procedure to a patient.

Subd. 3. **Clinically effective.** "Clinically effective" means that the use of a particular health technology or service improves or prevents a decline in patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology or service demonstrates a clinical or outcome advantage over alternative technologies or services. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health unless otherwise specified.

Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular service, device, or health technology to achieve improvement or prevent a decline in a patient's health outcome are justified given the comparison to both the economic costs and the improvement or prevention of decline in patient health outcome resulting from the use of an alternative service, device, or technology, or from not providing the service, device, or technology. This definition shall not be used to exclude or deny technology or treatment necessary to preserve life on the basis of an individual's age or expected length of life or of the individual's present or predicted disability, degree of medical dependency, or quality of life.

Subd. 6. **Group purchaser.** "Group purchaser" has the meaning provided in section 62J.03.

Subd. 7. **Health plan.** "Health plan" means a health plan as defined in section 62A.011.

Subd. 8. **Health plan company.** "Health plan company" has the meaning provided in section 62Q.01, subdivision 4. For the purposes of this chapter, health plan company shall include county-based purchasing arrangements authorized under section 256B.692.

Subd. 9. **Participating provider.** "Participating provider" means a provider who has entered into a service agreement with a health plan company.

Subd. 10. **Provider or health care provider.** "Provider" or "health care provider" means a health care provider as defined in section 62J.03, subdivision 8.

Subd. 10a. **Self-insurer.** "Self-insurer" has the meaning given in section 62E.02, subdivision 21.

Subd. 11. **Service agreement.** "Service agreement" means an agreement, contract, or other arrangement between a health plan company and a provider under which the provider agrees that when health services are provided for an enrollee, the provider shall not make a direct charge against the enrollee for those services or parts of services that are covered by the enrollee's contract, but shall look to the health plan company for the payment for covered services, to the extent they are covered.

Subd. 12. **State health care program.** "State health care program" means the medical assistance and MinnesotaCare programs.

Subd. 13. **Third-party administrator.** "Third-party administrator" means a vendor of risk-management services or an entity administering a self-insurance or health insurance plan under section 60A.23.

History: 2008 c 358 art 4 s 4; 2009 c 159 s 4; 2016 c 158 art 2 s 30; 2018 c 180 s 1

62U.02 PAYMENT RESTRUCTURING; QUALITY INCENTIVE PAYMENTS.

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures for use by health plan companies as specified in subdivision 5. As part of the standardized set of measures, the commissioner shall establish statewide 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 62U.03. The statewide measures shall be used for the quality incentive payment system developed in subdivision 2 and the quality transparency requirements in subdivision 3. The statewide measures must:

(1) for purposes of assessing the quality of care provided at physician clinics, including clinics certified as health care homes under section 62U.03, be selected from the available measures as defined in Code of Federal Regulations, title 42, part 414 or 495, as amended, unless the stakeholders identified under paragraph (b) determine that a particular diagnosis, condition, service, or procedure is not reflected in any of the available measures in a way that meets identified needs;

(2) be based on medical evidence;

(3) be developed through a process in which providers participate and consumer and community input and perspectives are obtained;

(4) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(5) seek to avoid increasing the administrative burden on health care providers; and

(6) place a priority on measures of health care outcomes, rather than process measures, wherever possible.

The measures may also include measures of care infrastructure and patient satisfaction.

(b) By June 30, 2018, the commissioner shall develop a measurement framework that identifies the most important elements for assessing the quality of care, articulates statewide quality improvement goals, ensures clinical relevance, fosters alignment with other measurement efforts, and defines the roles of stakeholders. By December 15, 2018, the commissioner shall use the framework to update the statewide measures used to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 62U.03. No more than six statewide measures shall be required for single-specialty physician practices and no more than ten statewide measures shall be required for multispecialty physician practices. Measures in addition to the six statewide measures for single-specialty practices and the ten statewide measures for multispecialty practices may be included for a physician practice if derived from administrative claims data. Care infrastructure measures collected according to section

62J.495 shall not be counted toward the maximum number of measures specified in this paragraph. The commissioner shall develop the framework in consultation with stakeholders that include consumer, community, and advocacy organizations representing diverse communities and patients; health plan companies; health care providers whose quality is assessed, including providers who serve primarily socioeconomically complex patient populations; health care purchasers; community health boards; and quality improvement and measurement organizations. The commissioner, in consultation with stakeholders, shall review the framework at least once every three years. The commissioner shall also submit a report to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by September 30, 2018, summarizing the development of the measurement framework and making recommendations on the type and appropriate maximum number of measures in the statewide measures set for implementation on January 1, 2020.

(c) Effective July 1, 2016, the commissioner shall stratify quality measures by race, ethnicity, preferred language, and country of origin beginning with five measures, and stratifying additional measures to the extent resources are available. On or after January 1, 2018, the commissioner may require measures to be stratified by other sociodemographic factors or composite indices of multiple factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. 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. The commissioner shall implement this paragraph in coordination with the contracting entity retained under subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

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

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, country of origin, and sociodemographic factors.

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

Subd. 3. Quality transparency. (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue periodic public reports on trends in provider quality at the statewide, regional, or clinic levels.

(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph (c), 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. The commissioner shall implement this paragraph in coordination with any contracting entity retained under subdivision 4.

(c) Physician clinics and hospitals shall submit standardized information for the identified statewide measures to the commissioner or the commissioner's designee in the formats specified by the commissioner, which must include alternative formats for clinics or hospitals experiencing technological or economic barriers to submission in standardized electronic form. The commissioner shall ensure that any quality data reporting requirements for physician clinics are aligned with the specifications and timelines for the selected measures as defined in subdivision 1, paragraph (a), clause (1). The commissioner may develop additional data on race, ethnicity, preferred language, country of origin, or other sociodemographic factors as identified under subdivision 1, paragraph (c), and as required for stratification or risk adjustment. None of the statewide measures selected shall require providers to use an external vendor to administer or collect data.

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, including providers serving high concentrations of patients and communities impacted by health disparities; 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.

Subd. 5. Implementation. Health plan companies shall use the standardized set of measures established under this section and shall not require providers to use and report health plan company-specific quality and outcome measures.

History: 2008 c 358 art 4 s 5; 2009 c 101 art 2 s 109; 2015 c 71 art 9 s 4-7; 1Sp2017 c 6 art 4 s 3; 2020 c 115 art 3 s 39

62U.03 HEALTH CARE HOMES.

Subdivision 1. **Payment restructuring and care coordination payments.** (a) By January 1, 2010, health plan companies shall include health care homes in their provider networks and by July 1, 2010, shall pay a care coordination fee for their members who choose to enroll in health care homes certified by the commissioner under this section. Health plan companies shall develop payment conditions and terms for the care coordination fee for health care homes participating in their network in a manner that is consistent with the system developed under section 256B.0753. Nothing in this section shall restrict the ability of health plan companies to selectively contract with health care providers, including health care homes. Health plan companies may reduce or reallocate payments to other providers to ensure that implementation of care coordination payments is cost neutral.

(b) By July 1, 2010, the commissioner of management and budget shall implement the care coordination payments for participants in the state employee group insurance program. The commissioner of management and budget may reallocate payments within the health care system in order to ensure that the implementation of this section is cost neutral.

Subd. 2. Definitions. (a) For purposes of this section, the following definitions apply.

(b) "Commissioner" means the commissioner of health.

(c) "Health plan company" has the meaning provided in section 62Q.01, subdivision 4.

(d) "Personal clinician" means a physician licensed under chapter 147, a physician assistant licensed and practicing under chapter 147A, or an advanced practice nurse licensed and registered to practice under chapter 148.

Subd. 3. Development and implementation of standards. (a) The commissioner of health shall develop and implement standards of certification for health care homes. In developing these standards, the commissioner shall consider existing standards developed by national independent accrediting and medical home organizations. The standards developed by the commissioner must meet the following criteria:

(1) emphasize, enhance, and encourage the use of primary care, and include the use of primary care physicians, advanced practice nurses, and physician assistants as personal clinicians;

(2) focus on delivering high-quality, efficient, and effective health care services;

(3) encourage patient-centered care, including active participation by the patient and family or a legal guardian, or a health care agent as defined in chapter 145C, as appropriate in decision making and care plan development, and providing care that is appropriate to the patient's race, ethnicity, and language;

(4) provide patients with a consistent, ongoing contact with a personal clinician or team of clinical professionals to ensure continuous and appropriate care for the patient's condition;

(5) ensure that health care homes develop and maintain appropriate comprehensive care plans for their patients with complex or chronic conditions, including an assessment of health risks and chronic conditions;

(6) enable and encourage utilization of a range of qualified health care professionals, including dedicated care coordinators, in a manner that enables providers to practice to the fullest extent of their license;

(7) focus initially on patients who have or are at risk of developing chronic health conditions;

(8) incorporate measures of quality, resource use, cost of care, and patient experience;

(9) ensure the use of health information technology and systematic follow-up, including the use of patient registries; and

(10) encourage the use of scientifically based health care, patient decision-making aids that provide patients with information about treatment options and their associated benefits, risks, costs, and comparative outcomes, and other clinical decision support tools.

(b) In developing these standards, the commissioner shall consult with national and local organizations working on health care home models, physicians, relevant state agencies, health plan companies, hospitals, other providers, patients, and patient advocates.

(c) For the purposes of developing and implementing these standards, the commissioner may use the expedited rulemaking process under section 14.389.

Subd. 4. Requirements for clinicians certified as health care homes. (a) A personal clinician or a primary care clinic may be certified as a health care home. If a primary care clinic is certified, all of the primary care clinic's clinicians must meet the criteria of a health care home. To be certified as a health care home, a clinician or clinic must meet the standards set by the commissioner in accordance with this section.

Certification as a health care home is voluntary. To maintain their status as health care homes, clinicians or clinics must renew their certification every three years.

(b) Clinicians or clinics certified as health care homes must offer their health care home services to all their patients with complex or chronic health conditions who are interested in participation.

(c) Health care homes must participate in the health care home collaborative established under subdivision 6.

Subd. 5. Alternative models and waivers of requirements. (a) Nothing in this section precludes the continued development of existing medical or health care home projects currently operating or under development by the commissioner of human services or precludes the commissioner of human services from establishing alternative models and payment mechanisms for persons who are enrolled in integrated Medicare and Medicaid programs under section 256B.69, subdivisions 23 and 28, are enrolled in managed care long-term care programs under section 256B.69, subdivision 6b, are dually eligible for Medicare and medical assistance, are in the waiting period for Medicare, or who have other primary coverage.

(b) The commissioner shall waive health care home certification requirements if an applicant demonstrates that compliance with a certification requirement will create a major financial hardship or is not feasible, and the applicant establishes an alternative way to accomplish the objectives of the certification requirement.

Subd. 6. Health care home collaborative. The commissioner shall establish a health care home collaborative to provide an opportunity for health care homes and state agencies to exchange information related to quality improvement and best practices.

Subd. 7. Evaluation and continued development. (a) For continued certification under this section, health care homes must meet process, outcome, and quality standards as developed and specified by the commissioner. The commissioner shall collect data from health care homes necessary for monitoring compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.

(b) The commissioner may contract with a private entity to perform an evaluation of the effectiveness of health care homes. Data collected under this subdivision is classified as nonpublic data under chapter 13.

Subd. 8. Outreach. The commissioner of human services shall encourage state health care program enrollees who have a complex or chronic condition to select a primary care clinic with clinicians who have been certified as health care homes.

Subd. 9. Coordination with local services. The health care home and the county shall coordinate care and services provided to patients enrolled with a health care home who have complex medical needs or a disability, and who need and are eligible for additional local services administered by counties, including but not limited to waived services, mental health services, social services, public health services, transportation, and housing. The coordination of care and services must be as provided in the plan established by the patient and the health care home.

Subd. 10. Pediatric care coordination. The commissioner of human services shall implement a pediatric care coordination service for children with high-cost medical or high-cost psychiatric conditions who are at risk of recurrent hospitalization or emergency room use for acute, chronic, or psychiatric illness, who receive medical assistance services. Care coordination services must be targeted to children not already receiving care coordination through another service and may include but are not limited to the provision of health care home services to children admitted to hospitals that do not currently provide care coordination. Care coordination services must be provided by care coordinators who are directly linked to provider teams in

the care delivery setting, but who may be part of a community care team shared by multiple primary care providers or practices. For purposes of this subdivision, the commissioner of human services shall, to the extent possible, use the existing health care home certification and payment structure established under this section and section 256B.0753.

Subd. 11. **Health care homes advisory committee.** (a) The commissioner shall establish a health care homes advisory committee to advise the commissioner on the ongoing statewide implementation of the health care homes program authorized in this section.

(b) The commissioner shall establish an advisory committee that includes representatives of the health care professions such as primary care providers, mental health providers, nursing and care coordinators, certified health care home clinics with statewide representation, health plan companies, state agencies, employers, academic researchers, consumers, and organizations that work to improve health care quality in Minnesota. At least 25 percent of the committee members must be consumers or patients in health care homes. The commissioner, in making appointments to the committee, shall ensure geographic representation of all regions of the state.

(c) The advisory committee shall advise the commissioner on ongoing implementation of the health care homes program, including, but not limited to, the following activities:

(1) implementation of certified health care homes across the state on performance management and implementation of benchmarking;

(2) implementation of modifications to the health care homes program based on results of the legislatively mandated health care homes evaluation;

(3) statewide solutions for engagement of employers and commercial payers;

(4) potential modifications of the health care homes rules or statutes;

(5) consumer engagement, including patient and family-centered care, patient activation in health care, and shared decision making;

(6) oversight for health care homes subject matter task forces or workgroups; and

(7) other related issues as requested by the commissioner.

(d) The advisory committee shall have the ability to establish subcommittees on specific topics. The advisory committee is governed by section 15.059. Notwithstanding section 15.059, the advisory committee does not expire.

History: 2008 c 358 art 2 s 1, art 4 s 6; 2009 c 101 art 2 s 109; 2009 c 159 s 91; 1Sp2011 c 9 art 6 s 54, 55; 2012 c 247 art 1 s 11; 2014 c 312 art 24 s 36; 2016 c 158 art 2 s 93; 2016 c 163 art 3 s 7; 2020 c 115 art 3 s 2, 29, 39

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) All health plan companies and third-party administrators shall submit encounter data on a monthly basis 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, for claims incurred on or after January 1, 2019, data deemed necessary by the commissioner to uniquely identify claims in the individual health insurance market; 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 the commissioner's 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.

(e) The commissioner shall compile summary information on the data submitted under this subdivision. The commissioner shall work with its vendors to assess the data submitted in terms of compliance with the data submission requirements and the completeness of the data submitted by comparing the data with summary information compiled by the commissioner and with established and emerging data quality standards to ensure data quality.

Subd. 5. Pricing data. (a) All health plan companies and third-party administrators shall submit, on a monthly basis, 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 the commissioner's 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. 5a. Self-insurers. The commissioner shall not require a self-insurer governed by the federal Employee Retirement Income Security Act of 1974 (ERISA) to comply with this section.

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.

Subd. 10. **Suspension.** Notwithstanding subdivisions 3, 3a, 3b, 3c, and 3d, the commissioner shall suspend the development and implementation of the provider peer grouping system required under this section. This suspension shall continue until the legislature authorizes the commissioner to resume this activity.

Subd. 11. **Restricted uses of the all-payer claims data.** (a) Notwithstanding subdivision 4, paragraph (b), and subdivision 5, paragraph (b), 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 as authorized under section 62U.03, subdivision 7;

(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, utilization, and illness burden based on geographical areas or populations;

(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; and

(5) to compile one or more public use files of summary data or tables that must:

(i) be available to the public for no or minimal cost by March 1, 2016, and available by web-based electronic data download by June 30, 2019;

(ii) not identify individual patients, payers, or providers;

(iii) be updated by the commissioner, at least annually, with the most current data available;

(iv) contain clear and conspicuous explanations of the characteristics of the data, such as the dates of the data contained in the files, the absence of costs of care for uninsured patients or nonresidents, and other disclaimers that provide appropriate context; and

(v) not lead to the collection of additional data elements beyond what is authorized under this section as of June 30, 2015.

(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.

(c) Nothing in this subdivision shall be construed to prohibit the commissioner from using the data collected under subdivision 4 to complete the state-based risk adjustment system assessment due to the legislature on October 1, 2015.

(d) The commissioner or the commissioner's designee may use the data submitted under subdivisions 4 and 5 for the purpose described in paragraph (a), clause (3), until July 1, 2023.

(e) The commissioner shall consult with the all-payer claims database work group established under subdivision 12 regarding the technical considerations necessary to create the public use files of summary data described in paragraph (a), clause (5).

Subd. 12. **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 this section. The work group shall develop recommendations based on the following questions and other topics as identified by the work group:

(1) what should the parameters be for allowable uses of the all-payer claims data collected under this section, beyond the uses authorized in subdivision 11;

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

(3) what type of funding or fee structure would be needed to support the expanded use of all-payer claims data;

(4) 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;

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

(6) 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 who are academic researchers with expertise in claims database analysis;

(6) two members representing two state agencies determined by the commissioner;

(7) one member representing the Minnesota Health Care Safety Net Coalition; and

(8) three members representing consumers.

(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. In considering the recommendations provided in the report, the legislature may consider whether the currently authorized uses of the all-payer claims data under this section should continue to be authorized.

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; 2014 c 178 s 1-4; 2014 c 275 art 1 s 10,11; 2015 c 71 art 8 s 8; 2016 c 179 s 2; 2018 c 180 s 2,3; 1Sp2019 c 9 art 8 s 16; 2020 c 115 art 3 s 3,39; 1Sp2021 c 7 art 3 s 8,9

62U.05 PROVIDER PRICING FOR BASKETS OF CARE.

Subdivision 1. **Establishment of definitions.** (a) By July 1, 2009, the commissioner of health shall establish uniform definitions for baskets of care beginning with a minimum of seven baskets of care. In selecting health conditions for which baskets of care should be defined, the commissioner shall consider coronary artery and heart disease, diabetes, asthma, and depression. In selecting health conditions, the

commissioner shall also consider the prevalence of the health conditions, the cost of treating the health conditions, and the potential for innovations to reduce cost and improve quality.

(b) The commissioner shall convene one or more work groups to assist in establishing these definitions. Each work group shall include members appointed by statewide associations representing relevant health care providers and health plan companies, and organizations that work to improve health care quality in Minnesota.

(c) To the extent possible, the baskets of care must incorporate a patient-directed, decision-making support model.

Subd. 2. Package prices. (a) Beginning January 1, 2010, health care providers may establish package prices for the baskets of care defined under subdivision 1.

(b) Beginning January 1, 2010, no health care provider or group of providers that has established a package price for a basket of care under this section shall vary the payment amount that the provider accepts as full payment for a health care service based upon the identity of the payer, upon a contractual relationship with a payer, upon the identity of the patient, or upon whether the patient has coverage through a group purchaser. This paragraph applies only to health care services provided to Minnesota residents or to non-Minnesota residents who obtain health insurance through a Minnesota employer. This paragraph does not apply to services paid for by Medicare, state public health care programs through fee-for-service or prepaid arrangements, workers' compensation, or no-fault automobile insurance. This paragraph does not affect the right of a provider to provide charity care or care for a reduced price due to financial hardship of the patient or due to the patient being a relative or friend of the provider.

Subd. 3. Quality measurements for baskets of care. (a) The commissioner shall establish quality measurements for the defined baskets of care by December 31, 2009. The commissioner may contract with an organization that works to improve health care quality to make recommendations about the use of existing measures or establishing new measures where no measures currently exist.

(b) Beginning July 1, 2010, the commissioner or the commissioner's designee shall publish comparative price and quality information on the baskets of care in a manner that is easily accessible and understandable to the public, as this information becomes available.

History: 2008 c 358 art 4 s 8

62U.06 COORDINATION; LEGISLATIVE OVERSIGHT.

Subdivision 1. Coordination. In carrying out the responsibilities of this chapter, the commissioner of health shall ensure that the activities and data collection are implemented in an integrated and coordinated manner that avoids unnecessary duplication of effort. To the extent possible, the commissioner shall use existing data sources and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

Subd. 2. Legislative oversight. Beginning January 15, 2009, the commissioner of health shall submit to the chairs and ranking minority members of the legislative committees with jurisdiction over health care policy and finance periodic progress reports on the implementation of this chapter and sections 62U.03 and 256B.0752 to 256B.0754.

Subd. 3. **Rulemaking.** For purposes of this chapter, the commissioner may use the expedited rulemaking process under section 14.389.

History: 2008 c 358 art 4 s 9; 1Sp2011 c 9 art 6 s 17; 2020 c 115 art 3 s 39

62U.07 SECTION 125 PLANS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meanings given them.

(b) "Employee" means an employee currently on an employer's payroll other than a retiree or disabled former employee.

(c) "Employer" means a person, firm, corporation, partnership, association, business trust, or other entity employing one or more persons, including a political subdivision of the state, filing payroll tax information on the employed person or persons.

(d) "Section 125 Plan" means a cafeteria or premium-only plan under section 125 of the Internal Revenue Code that allows employees to pay for health coverage premiums with pretax dollars.

(e) "Small employer" means an employer with two to 50 employees.

Subd. 2. **Section 125 Plan requirement.** (a) Effective July 1, 2009, all employers with 11 or more current full-time equivalent employees in this state shall establish and maintain a Section 125 Plan to allow their employees to purchase individual market or employer-based health coverage with pretax dollars. Nothing in this section requires employers to offer or purchase group health coverage for their employees. The following employers are exempt from the Section 125 Plan requirement:

- (1) employers that offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage;
- (2) employers that provide self-insurance as defined in section 62E.02; or
- (3) employers that have no employees who are eligible to participate in a Section 125 Plan.

(b) Notwithstanding paragraph (a), an employer may opt out of the requirement to establish a Section 125 Plan by sending a form to the commissioner of commerce. The commissioner of commerce shall create a check-box form for employers to opt out. The form must contain a check box indicating the employer is choosing to opt out and a check box indicating that the employer certifies they have received education and information on the advantages of Section 125 Plans. The commissioner of commerce shall make the form available through their website by April 1, 2009.

Subd. 3. **Employer requirements.** (a) Employers that do not offer a health plan as defined in section 62A.011, subdivision 3, that is group coverage and are required to offer or choose to offer a Section 125 Plan shall:

- (1) allow employees to purchase an individual market health plan for themselves and their dependents;
- (2) allow employees to choose any insurance producer licensed in accident and health insurance under chapter 60K to assist them in purchasing an individual market health plan;
- (3) upon an employee's request, deduct premium amounts on a pretax basis in an amount not to exceed an employee's wages, and remit these employee payments to the health plan; and

(4) provide notice to employees that individual market health plans purchased by employees through payroll deduction are not employer-sponsored or administered.

(b) Employers shall be held harmless from any and all claims related to the individual market health plans purchased by employees under a Section 125 Plan.

Subd. 4. **Section 125 Plan employer incentives.** (a) The commissioner of employment and economic development shall award grants to eligible small employers that establish Section 125 Plans.

(b) In order to be eligible for a grant, a small employer must:

(1) not have offered health insurance to employees through a group health insurance plan as defined in section 62A.10 or through a self-insured plan as defined in section 62E.02 in the 12 months prior to applying for grant funding under this section;

(2) have established a Section 125 Plan within 90 days prior to applying for grant funding under this section, and must not have offered a Section 125 Plan to employees for at least a nine-month period prior to the establishment of the Section 125 Plan under this section; and

(3) certify to the commissioner that the employer has established a Section 125 Plan and meets the requirements of subdivision 3.

(c) The amount of the grant awarded to a small employer under this section shall be \$350.

History: 2008 c 358 art 4 s 10

62U.071 [Repealed, 2009 c 3 s 2]

62U.08 ESSENTIAL BENEFIT SET.

Subdivision 1. **Work group created.** The commissioner of health shall convene a work group to make recommendations on the design of a health benefit set that provides coverage for a broad range of services and technologies, is based on scientific evidence that the services and technologies are clinically effective and cost-effective, and provides lower enrollee cost sharing for services and technologies that have been determined to be cost-effective. The work group shall include representatives of health care providers, health plans, state agencies, and employers. Members of the work group must have expertise in standards for evidence-based care, benefit design and development, actuarial analysis, or knowledge relating to the analysis of the cost impact of coverage of specified benefits. The work group must meet at least once per year and at other times as necessary to make recommendations to the commissioner on updating the benefit set as necessary to ensure that the benefit set continues to be safe, effective, and scientifically based.

Subd. 2. **Duties.** By October 15, 2009, the work group shall develop and submit to the commissioner an initial essential benefit set and design that includes coverage for a broad range of services, is based on scientific evidence that services are clinically effective and cost-effective, and provides lower enrollee cost sharing for services that have been determined to be cost-effective. The benefit set must include necessary evidence-based health care services, procedures, diagnostic tests, and technologies that are scientifically proven to be both clinically effective and cost-effective. In developing its recommendations, the work group may consult with the Institute for Clinical Systems Improvement (ICSI) to assemble existing scientifically based practice standards.

Subd. 3. **Report.** By January 15, 2010, the commissioner shall report the recommendations of the work group to the chairs and ranking minority members of the legislative committees and divisions with jurisdiction over health care policy and finance.

History: 2008 c 358 art 4 s 11

62U.09 [Repealed, 2014 c 286 art 7 s 14]

62U.10 HEALTH CARE TRANSFER, SAVINGS, AND REPAYMENT.

Subdivision 1. **Health care access fund transfer.** On June 30, 2009, the commissioner of management and budget shall transfer \$50,000,000 from the health care access fund to the general fund.

Subd. 2. **Projected spending baseline.** (a) By June 1, 2009, the commissioner of health shall calculate the annual projected total private and public health care spending for residents of this state and establish a health care spending baseline, beginning for calendar year 2008 and for the next ten years based on the annual projected growth in spending.

(b) In establishing the health care spending baseline, the commissioner shall use the Centers for Medicare and Medicaid Services forecast for total growth in national health care expenditures and adjust this forecast to reflect the demographics, health status, and other factors deemed necessary by the commissioner. The commissioner shall contract with an actuarial consultant to make recommendations for the adjustments needed to specifically reflect projected spending for residents of this state.

(c) The commissioner may adjust the projected baseline as necessary to reflect any updated federal projections or account for unanticipated changes in federal policy.

(d) Medicare and long-term care spending must not be included in the calculations required under this section.

Subd. 3. **Actual spending and savings determination.** By June 1, 2010, and each June 1 thereafter until June 1, 2020, the commissioner of health shall determine the actual total private and public health care spending for residents of this state for the calendar year two years before the current calendar year, based on data collected under chapter 62J, and shall determine the difference between the projected spending, as determined under subdivision 2, and the actual spending for that year. The actual spending must be certified by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner shall determine, based on the proportion of spending for state-administered health care programs to total private and public health care spending for the calendar year two years before the current calendar year, the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

Subd. 4. **Repayment of transfer.** When accumulated savings accruing to state-administered health care programs, as calculated under subdivision 3, meet or exceed \$50,000,000, the commissioner of health shall certify that event to the commissioner of management and budget. In the next fiscal year following the certification, the commissioner of management and budget shall transfer \$50,000,000 from the general fund to the health care access fund. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

Subd. 5. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Public health care spending" means spending for a state-administered health care program.

(c) "State-administered health care program" means medical assistance, MinnesotaCare, and the state employee group insurance program.

Subd. 6. **Projected spending baseline.** Beginning February 15, 2016, and each February 15 thereafter, the commissioner of health shall report the projected impact on spending from specified health indicators related to various preventable illnesses and death. The impacts shall be reported over a ten-year time frame using a baseline forecast of private and public health care and long-term care spending for residents of this state, beginning with calendar year 2009 projected estimates of costs, and updated annually for each of the following health indicators:

(1) costs related to rates of obesity, including obesity-related cancers, coronary heart disease, stroke, and arthritis;

(2) costs related to the utilization of tobacco products;

(3) costs related to hypertension;

(4) costs related to diabetes or prediabetes; and

(5) costs related to dementia and chronic disease among an elderly population over 60, including additional long-term care costs.

Subd. 7. **Outcomes reporting; savings determination.** (a) Beginning November 1, 2016, and each November 1 thereafter, the commissioner of health shall determine the actual total private and public health care and long-term care spending for Minnesota residents related to each health indicator projected in subdivision 6 for the most recent calendar year available. The commissioner shall determine the difference between the projected and actual spending for each health indicator and for each year, and determine the savings attributable to changes in these health indicators. The assumptions and research methods used to calculate actual spending must be determined to be appropriate by an independent actuarial consultant. If the actual spending is less than the projected spending, the commissioner, in consultation with the commissioners of human services and management and budget, shall use the proportion of spending for state-administered health care programs to total private and public health care spending for each health indicator for the calendar year two years before the current calendar year to determine the percentage of the calculated aggregate savings amount accruing to state-administered health care programs.

(b) The commissioner may use the data submitted under section 62U.04, subdivisions 4 and 5, to complete the activities required under this section, but may only report publicly on regional data aggregated to granularity of 25,000 lives or greater for this purpose.

Subd. 8. **Transfers.** When accumulated annual savings accruing to state-administered health care programs, as calculated under subdivision 7, meet or exceed \$50,000,000 for all health indicators in aggregate statewide, the commissioner of health shall certify that event to the commissioner of management and budget, no later than December 15 of each year. In the next fiscal year following the certification, the commissioner of management and budget shall transfer \$50,000,000 from the general fund to the health care access fund. This transfer shall repeat in each fiscal year following subsequent certifications of additional cumulative savings, up to \$50,000,000 per year. The amount necessary to make the transfer is appropriated from the general fund to the commissioner of management and budget.

History: 2008 c 363 art 17 s 1; 2009 c 101 art 2 s 109; 2015 c 71 art 8 s 9-11; 2016 c 158 art 2 s 31

62U.15 ALZHEIMER'S DISEASE; PREVALENCE AND SCREENING MEASURES.

Subdivision 1. **Data from providers.** (a) By July 1, 2012, the commissioner shall review currently available quality measures and make recommendations for future measurement aimed at improving assessment and care related to Alzheimer's disease and other dementia diagnoses, including improved rates and results of cognitive screening, rates of Alzheimer's and other dementia diagnoses, and prescribed care and treatment plans.

(b) The commissioner may contract with a private entity to complete the requirements in this subdivision. If the commissioner contracts with a private entity already under contract through section 62U.02, then the commissioner may use a sole source contract and is exempt from competitive procurement processes.

Subd. 2. MS 2018 [Repealed, 2020 c 115 art 3 s 40]

Subd. 3. **Comparison data.** The commissioner, with the commissioner of human services, the Minnesota Board on Aging, and other appropriate state offices, shall jointly review existing and forthcoming literature in order to estimate differences in the outcomes and costs of current practices for caring for those with Alzheimer's disease and other dementias, compared to the outcomes and costs resulting from:

- (1) earlier identification of Alzheimer's and other dementias;
- (2) improved support of family caregivers; and
- (3) improved collaboration between medical care management and community-based supports.

Subd. 4. **Reporting.** By January 15, 2013, the commissioner must report to the legislature on progress toward establishment and collection of quality measures required under this section.

History: *1Sp2011 c 9 art 2 s 4*