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State of Minnesota

HOUSE OF REPRESENTATIVES

EIGHTY-SIXTH SESSION

HOUSE FILE NO. 3056

February 18, 2010

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The bill was read for the first time and referred to the Committee on Health Care and Human Services Policy and Oversight

A bill for an act

relating to health; establishing a quality improvement program for physician clinics and hospitals; amending Minnesota Statutes 2008, section 62U.04, subdivisions 3, 6, 9, by adding a subdivision; repealing Minnesota Statutes 2009 Supplement, section 256B.032.

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

Section 1. Minnesota Statutes 2008, section 62U.04, subdivision 3, is amended to read:

Subd. 3. **Provider peer grouping.** (a) The commissioner shall develop a peer grouping system for providers based on a combined measure that incorporates both provider risk-adjusted cost of care and quality of care, and for specific conditions as determined by the commissioner. In developing this system, the commissioner shall consult and coordinate with health care providers, health plan companies, state agencies, and organizations that work to improve health care quality in Minnesota. 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) Beginning June 1, 2010, the commissioner shall disseminate information to providers on their cost of care, resource use, quality of care, and the results of the grouping developed under this subdivision in comparison to an appropriate peer group. 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 and submit comments. ~~The provider shall have 21 days to review the data for accuracy.~~

(c) The commissioner shall establish an appeals process to resolve disputes from providers regarding the accuracy of the data used to develop analyses or reports.

(d) Beginning September 1, ~~2010~~ 2011, the commissioner shall, no less than annually, publish information on providers' cost, quality, and the results of the peer grouping process. The results that are published must be on a risk-adjusted basis.

Sec. 2. Minnesota Statutes 2008, section 62U.04, is amended by adding a subdivision to read:

Subd. 3a. **Quality improvement.** Beginning June 1, 2010, the commissioner shall establish a quality improvement program for physician clinics and hospitals that utilizes the underlying data and results generated from the provider peer grouping system. The program shall annually provide physician clinics and hospitals with appropriate tools to understand their performance and to improve their results. The commissioner may choose to focus the program on those physician clinics and hospitals that deviate from identified thresholds of performance.

Sec. 3. Minnesota Statutes 2008, section 62U.04, subdivision 6, is amended to read:

Subd. 6. **Contracting.** (a) 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.

(b) The commissioner shall contract with a private entity or consortium of entities to manage and implement the quality improvement program for physician clinics and hospitals. The entity or consortium shall represent physicians and hospitals from all geographic areas of the state.

Sec. 4. Minnesota Statutes 2008, section 62U.04, subdivision 9, is amended to read:

Subd. 9. **Uses of information.** (a) By January 1, ~~2011~~ 2012:

(1) the commissioner of management and budget ~~shall~~ may use the information and methods developed under subdivision 3 to strengthen incentives for members of the state employee group insurance program to use high-quality, low-cost providers;

(2) all political subdivisions, as defined in section 13.02, subdivision 11, that offer health benefits to their employees ~~must~~ may offer plans that differentiate providers on their

cost and quality performance and create incentives for members to use better-performing providers;

(3) all health plan companies ~~shall~~ may use the information and methods developed under subdivision 3 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 ~~must~~ may offer at least one health plan that uses the information developed under subdivision 3 to establish financial incentives for consumers to choose higher-quality, lower-cost providers through enrollee cost-sharing or selective provider networks.

(b) By January 1, ~~2011~~ 2012, the commissioner of health shall report to the governor and the legislature on recommendations to encourage health plan companies to promote widespread adoption of products that encourage the use of high-quality, low-cost providers. The commissioner's recommendations may include tax incentives, public reporting of health plan performance, regulatory incentives or changes, and other strategies.

Sec. 5. **REPEALER.**

Minnesota Statutes 2009 Supplement, section 256B.032, is repealed.

256B.032 ELIGIBLE VENDORS OF MEDICAL CARE.

(a) Effective January 1, 2011, the commissioner shall establish performance thresholds for health care providers included in the provider peer grouping system developed by the commissioner of health under section 62U.04. The thresholds shall be set at the 10th percentile of the combined cost and quality measure used for provider peer grouping, and separate thresholds shall be set for hospital and physician services.

(b) Beginning January 1, 2012, any health care provider with a combined cost and quality score below the threshold set in paragraph (a) shall be prohibited from enrolling as a vendor of medical care in the medical assistance, general assistance medical care, or MinnesotaCare programs, and shall not be eligible for direct payments under those programs or for payments made by managed care plans under their contracts with the commissioner under section 256B.69 or 256L.12. A health care provider that is prohibited from enrolling as a vendor or receiving payments under this paragraph may reenroll effective January 1 of any subsequent year if the provider's most recent combined cost and quality score exceeds the threshold established in paragraph (a).

(c) Notwithstanding paragraph (b), a provider may continue to participate as a vendor or as part of a managed care plan provider network if the commissioner determines that a contract with the provider is necessary to ensure adequate access to health care services.

(d) By January 15, 2013, the commissioner shall report to the legislature on the impact of this section. The commissioner's report shall include information on:

(1) the providers falling below the thresholds as of January 1, 2012;

(2) the volume of services and cost of care provided to enrollees in the medical assistance, general assistance medical care, or MinnesotaCare programs in the 12 months prior to January 1, 2012, by providers falling below the thresholds;

(3) providers who fell below the thresholds but continued to be eligible vendors under paragraph (c);

(4) the estimated cost savings achieved by not contracting with providers who do not meet the performance thresholds; and

(5) recommendations for increasing the threshold levels of performance over time.