CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.01 FINDINGS.

The legislature finds that substantial numbers of Minnesotans have no health care coverage and that most of these residents are wage earners or their dependents. One-third of these individuals are children.

The legislature further finds that when these individuals enter the health care system they have often foregone preventive care and are in need of more expensive treatment that often exceeds their financial resources. Much of the cost for these uncompensated services to the uninsured are already in the health care system in the form of increased insurance and provider rates and property and income taxes.

The legislature further finds that these costs, spread among the already insured, represent a woefully inefficient method for providing basic preventive and acute care for the uninsured and represent an added cost to employers now providing health insurance to their employees.

The legislature further finds that it is necessary to ensure basic and affordable health care to all Minnesotans while addressing the economic pressures on the health care system as a whole in Minnesota.

History: *1989 c 327 s 1*

COST CONTROLS

62J.015 PURPOSE.

The legislature finds that the staggering growth in health care costs is having a devastating effect on the health and cost of living of Minnesota residents. The legislature further finds that the number of uninsured and underinsured residents is growing each year and that the cost of health care coverage for our insured residents is increasing annually at a rate that far exceeds the state's overall rate of inflation.

The legislature further finds that it must enact immediate and intensive cost containment measures to limit the growth of health care expenditures, reform insurance practices, and finance a plan that offers access to affordable health care for our permanent residents by capturing dollars now lost to inefficiencies in Minnesota's health care system.

The legislature further finds that controlling costs is essential to the maintenance of the many factors contributing to the quality of life in Minnesota: our environment, education system, safe communities, affordable housing, provision of food, economic vitality, purchasing power, and stable population.

It is, therefore, the intent of the legislature to lay a new foundation for the delivery and financing of health care in Minnesota and to call this new foundation the Minnesota health right act.

History: *1992 c 549 art 1 s 1*

62J.02 [Repealed, 1989 c 327 s 4]

62J.03 DEFINITIONS.

Subdivision 1. **Scope of definitions.** For purposes of this chapter, the terms defined in this section have the meanings given.

Subd. 2. **Clinically effective.** "Clinically effective" means that the use of a particular medical technology improves patient clinical status, as measured by medical condition, survival rates, and other variables, and that the use of the particular technology demonstrates a clinical advantage over alternative technologies.

Subd. 3. **Commission.** "Commission" or "state commission" means the Minnesota health care commission established in section 62J.05.

Subd. 4. **Commissioner.** "Commissioner" means the commissioner of health.

Subd. 5. **Cost effective.** "Cost effective" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies.

Subd. 6. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, health insurance companies, health maintenance organizations and other health plan companies; employee health plans offered by self-insured employers; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

Subd. 7. **Improvement in health outcome.** "Improvement in health outcome" means an improvement in patient clinical status, and an improvement in patient quality-of-life status, as measured by ability to function, ability to return to work, and other variables.

Subd. 8. **Provider.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee, as further defined in rules adopted by the commissioner.

History: *1992 c 549 art 1 s 2*

62J.04 CONTROLLING THE RATE OF GROWTH OF HEALTH CARE SPENDING.

Subdivision 1. **Comprehensive budget.** The commissioner of health shall set an annual limit on the rate of growth of public and private spending on health care services for Minnesota residents. The limit on growth must be set at a level that will slow the current rate of growth by at least ten percent per year using the spending growth rate for 1991 as a base year. This limit must be achievable through good faith, cooperative efforts of health care consumers, purchasers, and providers.

Subd. 2. **Data collection.** For purposes of setting limits under this section, the commissioner shall collect from all Minnesota health care providers data on patient revenues received during a time period specified by the commissioner. The commissioner shall also collect data on health care spending from all group purchasers of health care. All health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements. Intentional failure to provide reports requested under this section is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider. The commissioner may assess a fine against a provider who refuses to provide information required by the commis-

sioner under this section. If a provider refuses to provide a report or information required under this section, the commissioner may obtain a court order requiring the provider to produce documents and allowing the commissioner to inspect the records of the provider for purposes of obtaining the information required under this section. All data received is nonpublic, trade secret information under section 13.37. The commissioner shall establish procedures and safeguards to ensure that data provided to the Minnesota health care commission is in a form that does not identify individual patients, providers, employers, purchasers, or other individuals and organizations, except with the permission of the affected individual or organization.

Subd. 3. **Cost containment duties.** After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality;

(5) develop uniform billing forms, uniform electronic billing procedures, and other uniform claims procedures for health care providers by January 1, 1993;

(6) undertake health planning responsibilities as provided in section 62J.15;

(7) monitor and promote the development and implementation of practice parameters;

(8) authorize, fund, or promote research and experimentation on new technologies and health care procedures;

(9) designate centers of excellence for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services;

(11) administer the health care analysis unit under Laws 1992, chapter 549, article 7; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Subd. 4. **Consultation with the commission.** Before undertaking any of the duties required under this chapter, the commissioner of health shall consult with the Minnesota health care commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative oversight commission of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative oversight commission must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice and an opportunity for comment as required in this subdivision, the

commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative oversight commission at the earliest possible time.

Subd. 5. **Appeals.** A person or organization may appeal a decision of the commissioner through a contested case proceeding under chapter 14.

Subd. 6. **Rulemaking.** The commissioner shall adopt rules under chapter 14 to implement this chapter, including appeals of decisions by the Minnesota health care commission and the regional coordinating boards.

Subd. 7. **Plan for controlling growth in spending.** (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate identified by the commission, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. The commission shall use the rate of spending growth in 1991 as the base year for developing its plan. The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Minnesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending;

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care; and

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

History: *1992 c 549 art 1 s 3*

62J.05 MINNESOTA HEALTH CARE COMMISSION.

Subdivision 1. **Purpose of the commission.** The Minnesota health care commission consists of health care providers, purchasers, consumers, employers, and employees. The two major functions of the commission are:

(1) to make recommendations to the commissioner of health and the legislature regarding statewide and regional limits on the rate of growth of health care spending and activities to prevent or address spending in excess of the limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. **Membership.** (a) **Number.** The Minnesota health care commission consists of 25 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population.

(b) **Health plan companies.** The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) **Health care providers.** The commission includes six members representing health care providers, including one member appointed by the Minnesota Hospital Association, one member appointed by the Minnesota Medical Association, one member appointed by the Minnesota Nurses' Association, one rural physician appointed by the governor, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) **Employers.** The commission includes four members representing employers, including (1) two members appointed by the Minnesota Chamber of Commerce, including one self-insured employer and one small employer; and (2) two members appointed by the governor.

(e) **Consumers.** The commission includes five consumer members, including three members appointed by the governor, one of whom must represent persons over age 65; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) **Employee unions.** The commission includes three representatives of labor unions, including two appointed by the AFL-CIO Minnesota and one appointed by the governor to represent other unions.

(g) **State agencies.** The commission includes the commissioners of commerce, employee relations, and human services.

(h) **Chair.** The governor shall designate the chair of the commission from among the governor's appointees.

Subd. 3. **Financial interests of members.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 4. **Conflicts of interest.** No member may participate or vote in commission proceedings involving an individual provider, purchaser, or patient, or a specific activ-

ity or transaction, if the member has a direct financial interest in the outcome of the commission's proceedings other than as an individual consumer of health care services.

Subd. 5. **Immunity from liability.** No member of the commission shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

Subd. 6. **Terms; compensation; removal; and vacancies.** The commission is governed by section 15.0575.

Subd. 7. **Administration.** The commissioner of health shall provide office space, equipment and supplies, and technical support to the commission.

Subd. 8. **Staff.** The commission may hire an executive director who serves in the unclassified service. The executive director may hire employees and consultants as authorized by the commission and may prescribe their duties. The attorney general shall provide legal services to the commission.

History: *1992 c 549 art 1 s 4*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The legislative commission on health care access reviews the activities of the commissioner of health, the state health care commission, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

Subd. 2. **Membership.** The legislative commission on health care access consists of five members of the senate appointed under the rules of the senate and five members of the house of representatives appointed under the rules of the house of representatives. The legislative commission on health care access must include three members of the majority party and two members of the minority party in each house.

Subd. 3. **Reports to the commission.** The commissioner of health and the Minnesota health care commission shall report on their activities and the activities of the regional boards annually and at other times at the request of the legislative commission on health care access. The commissioners of health, commerce, and human services shall provide periodic reports to the legislative commission on the progress of rulemaking that is authorized or required under this act and shall notify members of the commission when a draft of a proposed rule has been completed and scheduled for publication in the State Register. At the request of a member of the commission, a commissioner shall provide a description and a copy of a proposed rule.

Subd. 4. **Report on revenue sources.** The legislative commission on health care access shall study the long-term integrity and stability of the revenue sources created in Laws 1992, chapter 549, as the funding mechanism for the health right program and related health care initiatives. The study must include:

(1) an analysis of the impact of the provider taxes on the health care system and the relationship between the taxes and other initiatives related to health care access, affordability, and quality;

(2) the adequacy of the revenues generated in relation to the costs of a fully implemented and appropriately designed health right program;

(3) the extent to which provider taxes are passed on to individual and group purchasers and the ability of individual providers and groups of providers to absorb all or part of the tax burden;

(4) alternative funding sources and financing methods; and

(5) other appropriate issues relating to the financing of the health right program and related initiatives.

The commission shall provide a preliminary report and recommendations to the legislature by January 15, 1993, and a final report and recommendations by January 15, 1994. The commissioners of revenue, human services, and health shall provide assistance to the commission.

History: *1992 c 549 art 1 s 5*

62J.09 REGIONAL COORDINATING BOARDS.

Subdivision 1. **General duties.** The regional coordinating boards are locally controlled boards consisting of providers, health plan companies, employers, consumers, and elected officials. Regional boards may:

(1) recommend that the commissioner sanction voluntary agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction;

(2) make recommendations to the commissioner regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by providers;

(3) undertake voluntary activities to educate consumers, providers, and purchasers or to promote voluntary, cooperative community cost containment, access, or quality of care projects;

(4) make recommendations to the commissioner regarding ways of improving affordability, accessibility, and quality of health care in the region and throughout the state.

Subd. 2. **Membership.** (a) Each regional health care management board consists of 16 members as provided in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence.

(b) **Provider representatives.** Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) **Health plan company representatives.** Each regional board includes three members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) **Employer representatives.** Regional boards include three members representing employers in the region. Employer representatives are elected by a vote of the employers who are members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) **Employee unions.** Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) **Public members.** Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) **County commissioner.** Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) **State agency.** Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Subd. 3. **Establishment of regional coordinating organizations and structure.** The providers of health services in each region should begin formulating the appropriate structure for organizing the delivery networks or systems to accomplish the objectives in subdivision 1. Once a draft plan is outlined, or during the drafting process, other

entities should be included as appropriate so as to ensure the comprehensiveness of the plan and the regional planning process. The ultimate structure of the regional coordinating organization may vary by region and in composition. Each region may consult with the commissioner of health and the Minnesota health care commission during the planning process.

Subd. 4. **Financial interests of members.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 5. **Conflicts of interest.** No member may participate or vote in board proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the board's proceedings other than as an individual consumer of health care services.

Subd. 6. **Technical assistance.** The state health care commission shall provide technical assistance to regional boards.

Subd. 7. **Terms; compensation; removal; and vacancies.** Regional coordinating boards are governed by section 15.0575, except that members do not receive per diem payments.

Subd. 8. **Repealer.** This section is repealed effective July 1, 1993.

History: *1992 c 549 art 1 s 6; 1992 c 603 s 28*

62J.15 HEALTH PLANNING.

Subdivision 1. **Health planning advisory committee.** The Minnesota health care commission shall convene an advisory committee to make recommendations regarding the use and distribution of new and existing health care technologies and procedures and major capital expenditures by providers. The advisory committee may include members of the state commission and other persons appointed by the commission. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies and procedures include high-cost pharmaceuticals, organ and other high-cost transplants, high-cost health care procedures and devices excluding United States Food and Drug Administration approved implantable or wearable medical devices, and expensive, large-scale technologies such as scanners and imagers.

Subd. 2. **Health planning.** In consultation with the health planning advisory committee, the Minnesota health care commission shall:

(1) make recommendations on the types of high-cost technologies, procedures, and capital expenditures for which a plan on statewide use and distribution should be made;

(2) develop criteria for evaluating new high-cost health care technology and procedures and major capital expenditures that take into consideration the clinical effectiveness, cost-effectiveness, and health outcome;

(3) recommend to the commissioner of health and the regional coordinating organizations statewide and regional goals and targets for the distribution and use of new and existing high-cost health care technologies and procedures and major capital expenditures;

(4) make recommendations to the commissioner regarding the designation of centers of excellence for transplants and other specialized medical procedures; and

(5) make recommendations to the commissioner regarding minimum volume requirements for the performance of certain procedures by hospitals and other health care facilities or providers.

History: *1992 c 549 art 1 s 7*

62J.17 EXPENDITURE REPORTING.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

Subd. 2. **Definitions.** For purposes of this section, the terms defined in this subdivision have the meanings given.

(a) **Capital expenditure.** "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

(b) **Health care service.** "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

(c) **Major spending commitment.** "Major spending commitment" means:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

(d) **Medical equipment.** "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

(e) **New specialized service.** "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

(f) **Provider.** "Provider" means an individual, corporation, association, firm, partnership, or other entity that is regularly engaged in providing health care services in Minnesota.

Subd. 3. **Hospital and nursing home moratoria preserved; nursing homes exempt.** Nothing in this section supersedes or limits the applicability of section 144.551 or 144A.071. This section does not apply to major spending commitments made by nursing homes or intermediate care facilities that are related to the provision of long-term care services to residents.

Subd. 4. **Expenditure reporting.** Any provider making a capital expenditure establishing a health care service or new specialized service, or making a major spending commitment after April 1, 1992, that is in excess of $500,000, shall submit notification of this expenditure to the commissioner and provide the commissioner with any relevant background or other information. The commissioner shall not have any approval or denial authority, but should use such information in the ongoing evaluation of statewide and regional progress toward cost containment and other objectives.

Subd. 5. **Retrospective review.** The commissioner of health, in consultation with the Minnesota health care commission, shall retrospectively review capital expenditures and major spending commitments that are required to be reported by providers under subdivision 4. In the event that health care providers refuse to cooperate with attempts by the Minnesota health care commission and regional coordinating organizations to coordinate the use of health care technologies and procedures, and reduce the growth rate in health care expenditures; or in the event that health care providers use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective and do not improve health outcomes based on the results of medical research; or in the event providers have failed to pursue collaborative arrangements; the commissioner shall require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Subd. 6. **Prospective review and approval.** (a) **Requirement.** The commissioner shall prohibit those health care providers subject to retrospective review under subdivision 5 from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4 for a period of up to five years, unless: (1) the provider has filed an application to proceed with the major spending commitment or capital expenditure with the commissioner and provided supporting documentation and evidence requested by the commissioner; and (2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate. The commissioner shall make a decision on a completed application within 60 days after an application is submitted. The Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, and health care expenditures to review applications and make recommendations to the commissioner and the commission.

(b) **Exceptions.** This subdivision does not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state;

(2) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant, or clinical trials;

(3) a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and

(4) mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

(c) **Appeals.** A provider may appeal a decision of the commissioner under this section through a contested case proceeding under chapter 14.

(d) **Penalties and remedies.** The commissioner of health shall have the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

History: *1992 c 549 art 1 s 8*

62J.19 SUBMISSION OF REGIONAL PLAN TO COMMISSIONER.

Each regional coordinating board shall submit its plan to the commissioner on or before June 30, 1993. In the event that any major provider, provider group or other entity within the region chooses to not participate in the regional planning process, the commissioner may require the participation of that entity in the planning process or adopt other rules or criteria for that entity. In the event that a region fails to submit a plan to the commissioner that satisfactorily promotes the objectives in section 62J.09, subdivisions 1 and 2, or where competing plans and regional coordination boards exist, the commissioner has the authority to establish a public regional coordinating board for purposes of establishing a regional plan which will achieve the objectives. The public regional coordinating board shall be appointed by the commissioner and under the commissioner's direction.

History: *1992 c 549 art 1 s 9; 1992 c 603 s 29*

62J.21 REPORTING TO THE LEGISLATURE.

The commissioner shall report to the legislature by January 1, 1993, regarding the process being made within each region with respect to the establishment of a regional coordinating board and the development of a regional plan. In the event that the commissioner determines that any region is not making reasonable progress or a good-faith commitment towards establishing a regional coordinating board and regional plan, the commissioner may establish a public regional board for this purpose. The commissioner's report should also include the issues, if any, raised during the planning process to date and request any appropriate legislative action that would facilitate the planning process.

History: *1992 c 549 art 1 s 10; 1992 c 603 s 30*

62J.22 PARTICIPATION OF FEDERAL PROGRAMS.

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall under the direction of the health care commission submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. Other state agencies shall provide assistance at the request of the commission. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be

adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

History: *1992 c 549 art 1 s 11*

62J.23 PROVIDER CONFLICTS OF INTEREST.

Subdivision 1. **Rules prohibiting conflicts of interest.** The commissioner of health shall adopt rules restricting financial relationships or payment arrangements involving health care providers under which a provider benefits financially by referring a patient to another provider, recommending another provider, or furnishing or recommending an item or service. The rules must be compatible with, and no less restrictive than, the federal Medicare antikickback statute, in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and regulations adopted under it. However, the commissioner's rules may be more restrictive than the federal law and regulations and may apply to additional provider groups and business and professional arrangements. When the state rules restrict an arrangement or relationship that is permissible under federal laws and regulations, including an arrangement or relationship expressly permitted under the federal safe harbor regulations, the fact that the state requirement is more restrictive than federal requirements must be clearly stated in the rule.

Subd. 2. **Interim restrictions.** From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all health care providers in the state, regardless of whether the provider participates in any state health care program. The commissioner shall approve a transition plan submitted to the commissioner by January 1, 1993, by a provider who is in violation of this section that provides a reasonable time for the provider to modify prohibited practices or divest financial interests in other providers in order to come into compliance with this section.

Subd. 3. **Penalty.** The commissioner may assess a fine against a provider who violates this section. The amount of the fine is $1,000 or 110 percent of the estimated financial benefit that the provider realized as a result of the prohibited financial arrangement or payment relationship, whichever is greater. A provider who is in compliance with a transition plan approved by the commissioner under subdivision 2, or who is making a good faith effort to obtain the commissioner's approval of a transition plan, is not in violation of this section.

History: *1992 c 549 art 1 s 12*

NOTE: Subdivision 3, as added by Laws 1992, chapter 549, article 1, section 12, is effective July 1, 1993. See Laws 1992, chapter 549, article 1, section 20.

62J.25 MANDATORY MEDICARE ASSIGNMENT.

(a) Effective January 1, 1993, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 115 percent of the Medicare-approved amount for any Medicare-covered service provided.

(b) Effective January 1, 1994, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 110 percent of the Medicare-approved amount for any Medicare-covered service provided.

(c) Effective January 1, 1995, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of 105 percent of the Medicare-approved amount for any Medicare-covered service provided.

(d) Effective January 1, 1996, a health care provider authorized to participate in the Medicare program shall not charge to or collect from a Medicare beneficiary who is a Minnesota resident any amount in excess of the Medicare-approved amount for any Medicare-covered service provided.

(e) This section does not apply to ambulance services as defined in section 144.801, subdivision 4.

History: *1992 c 549 art 1 s 13*

62J.29 ANTITRUST EXCEPTIONS.

Subdivision 1. **Purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by some cooperative arrangements involving providers or purchasers that would be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of this section is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the competitive marketplace. The legislature intends that approval of relationships be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power.

Subd. 2. **Review and approval.** The commissioner shall establish criteria and procedures to review and authorize contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter. The commissioner shall not approve any application unless the commissioner finds that the proposed arrangement is likely to result in lower health care costs, or greater access to or quality of health care, than would occur in the competitive marketplace. The commissioner may condition approval of a proposed arrangement on a modification of all or part of the arrangement to eliminate any restriction on competition that is not reasonably related to the goals of controlling costs or improving access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against any abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state. The commissioner shall actively monitor and regulate arrangements approved under this section to ensure that the arrangements remain in compliance with the conditions of approval. The commissioner may revoke an approval upon a finding that the arrangement is not in substantial compliance with the terms of the application or the conditions of approval.

Subd. 3. **Applications.** Applications for approval under this section must be filed with the commissioner. An application for approval must describe the proposed arrangement in detail. The application must include at least: the identities of all parties, the intent of the arrangement, the expected effects of the arrangement, an explanation of how the arrangement will control costs or improve access or quality, and financial statements showing how the efficiencies of operation will be passed along to patients and purchasers of health care. The commissioner may ask the attorney general to comment on an application, but the application and any information obtained by the commissioner under this section is not admissible in any proceeding brought by the attorney general based on antitrust.

Subd. 4. **State antitrust law.** Notwithstanding the Minnesota antitrust law of 1971, as amended, in sections 325D.49 to 325D.66, contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that are approved by the commissioner under this section do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce under sections 325D.49 to 325D.66. Approval by the state commission is an absolute defense against any action under state antitrust laws.

Subd. 5. **Rulemaking.** The commissioner shall by January 1, 1994, adopt permanent rules to implement this section. The commissioner is exempt from rulemaking until January 1, 1994.

History: *1992 c 549 art 1 s 14*

DATA COLLECTION AND RESEARCH INITIATIVES

62J.30 HEALTH CARE ANALYSIS UNIT.

Subdivision 1. **Definitions.** For purposes of sections 62J.30 to 62J.34, the following definitions apply:

(a) "Practice parameter" means a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies, including those studies sponsored by the federal agency for health care policy and research, or has been adopted for use by a national medical society.

(b) "Outcomes research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

Subd. 2. **Establishment.** The commissioner of health, in consultation with the Minnesota health care commission, shall establish a health care analysis unit to conduct data and research initiatives in order to improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. **General duties; implementation date.** The commissioner, through the health care analysis unit, shall:

(1) conduct applied research using existing and newly established health care data bases, and promote applications based on existing research;

(2) establish the condition-specific data base required under section 62J.31;

(3) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health carriers, as defined in section 62L.02, subdivision 16;

(4) work closely with health carriers and health care providers to promote improvements in health care efficiency and effectiveness;

(5) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management;

(6) provide technical assistance to health plan and health care purchasers, as required by section 62J.33;

(7) develop outcome-based practice parameters as required under section 62J.34; and

(8) provide technical assistance as needed to the health planning advisory committee and the regional coordinating boards.

Subd. 4. **Criteria for unit initiatives.** Data and research initiatives by the health care analysis unit must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of low-income people, and health carriers;

(2) promote a significantly accelerated pace of publicly disseminated, applied research on health care delivery, outcomes, costs, quality, and management;

(3) conduct research and promote health care applications based on scientifically sound and statistically valid methods;

(4) be statewide in scope, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative data base for research, comparisons, and applications;

(5) emphasize data that is useful, relevant, and nonredundant of existing data. The initiatives may duplicate existing private activities, if this is necessary to ensure that the data collected will be in the public domain;

(6) be structured to minimize the administrative burden on health carriers, health care providers, and the health care delivery system, and minimize any privacy impact on individuals; and

(7) promote continuous improvement in the efficiency and effectiveness of health care delivery.

Subd. 5. **Criteria for public sector health care programs.** Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

(4) provide a data source that allows the evaluation of state health care financing and delivery programs.

Subd. 6. **Data collection procedures.** The health care analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden providers. The unit may require health care providers and health carriers to collect and provide patient health records, provide mailing lists of patients who have consented to release of data, and cooperate in other ways with the data collection process. For purposes of this chapter, the health care analysis unit shall assign, or require health care providers and health carriers to assign, a unique identification number to each patient to safeguard patient identity.

Subd. 7. **Data classification.** (a) Data collected through the large-scale data base initiatives of the health care analysis unit required by section 62J.31 that identify individuals are private data on individuals. Data not on individuals are nonpublic data. The commissioner may release private data on individuals and nonpublic data to researchers affiliated with university research centers or departments who are conducting research on health outcomes, practice parameters, and medical practice style; researchers working under contract with the commissioner; and individuals purchasing health care services for health carriers and groups. Prior to releasing any nonpublic or private data under this paragraph that identify or relate to a specific health carrier, medical provider, or health care facility, the commissioner shall provide at least 30 days' notice to the subject of the data, including a copy of the relevant data, and allow the subject of the data to provide a brief explanation or comment on the data which must be released with the data. To the extent reasonably possible, release of private or confidential data under this chapter shall be made without releasing data that could reveal the identity of individuals and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale data base initiatives of the health care analysis unit may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner.

(c) The commissioner shall adopt rules to establish criteria and procedures to govern access to and the use of data collected through the initiatives of the health care analysis unit.

Subd. 8. **Data collection advisory committee.** The commissioner shall convene a 15-member data collection advisory committee consisting of health service researchers, health care providers, health carrier representatives, representatives of businesses that purchase health coverage, and consumers. Six members of this committee must be health care providers. The advisory committee shall evaluate methods of data collection and shall recommend to the commissioner methods of data collection that minimize administrative burdens, address data privacy concerns, and meet the needs of health service researchers. The advisory committee is governed by section 15.059.

Subd. 9. **Federal and other grants.** The commissioner shall seek federal funding,

and funding from private and other nonstate sources, for the initiatives of the health care analysis unit.

Subd. 10. **Contracts and grants.** To carry out the duties assigned in sections 62J.30 to 62J.34, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data on individuals which it receives according to the statutory provisions applicable to the data.

Subd. 11. **Rulemaking.** The commissioner may adopt permanent and emergency rules to implement sections 62J.30 to 62J.34.

History: *1992 c 549 art 7 s 1*

62J.31 LARGE-SCALE DATA BASE.

Subdivision 1. **Establishment.** The health care analysis unit shall establish a large-scale data base for a limited number of health conditions. This initiative must meet the requirements of this section.

Subd. 2. **Specific health conditions.** (a) The data must be collected for specific health conditions, rather than specific procedures, types of health care providers, or services. The health care analysis unit shall designate a limited number of specific health conditions for which data shall be collected during the first year of operation. For subsequent years, data may be collected for additional specific health conditions. The number of specific conditions for which data is collected is subject to the availability of appropriations.

(b) The initiative must emphasize conditions that account for significant total costs, when considering both the frequency of a condition and the unit cost of treatment. The initial emphasis must be on the study of conditions commonly treated in hospitals on an inpatient or outpatient basis, or in freestanding outpatient surgical centers. This initial emphasis may be expanded to include entire episodes of care for a given condition, whether or not treatment includes use of a hospital or a freestanding outpatient surgical center, if adequate data collection and evaluation techniques are available for that condition.

Subd. 3. **Information to be collected.** The data collected must include information on health outcomes, including information on mortality, morbidity, patient functional status and quality of life, symptoms, and patient satisfaction. The data collected must include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records. The data must be collected in a manner that allows comparisons to be made between providers, health carriers, public programs, and other entities.

Subd. 4. **Data collection and review.** Data collection for any one condition must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; and monitoring for changes in practice patterns. The health care analysis unit shall annually review all specific health conditions for which data is being collected, in order to determine if data collection for that condition should be continued.

Subd. 5. **Use of existing data bases.** (a) The health care analysis unit shall negotiate with private sector organizations currently collecting data on specific health conditions of interest to the unit, in order to obtain required data in a cost-effective manner and minimize administrative costs. The unit shall attempt to establish linkages between the large scale data base established by the unit and existing private sector data bases and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The health care analysis unit shall use existing public sector data bases, such as those existing for medical assistance and Medicare, to the greatest extent possible. The unit shall establish linkages between existing public sector data bases and consider and implement methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

History: *1992 c 549 art 7 s 2*

62J.32 ANALYSIS AND USE OF DATA COLLECTED THROUGH THE LARGE-SCALE DATA BASE.

Subdivision 1. **Data analysis.** The health care analysis unit shall analyze the data collected on specific health conditions using existing practice parameters and newly researched practice parameters, including those established through the outcomes research studies of the federal government. The unit may use the data collected to develop new practice parameters, if development and refinement is based on input from and analysis by practitioners, particularly those practitioners knowledgeable about and impacted by practice parameters. The unit may also refine existing practice parameters, and may encourage or coordinate private sector research efforts designed to develop or refine practice parameters.

Subd. 2. **Educational efforts.** The health care analysis unit shall maintain and improve the quality of health care in Minnesota by providing practitioners in the state with information about practice parameters. The unit shall promote, support, and disseminate parameters for specific, appropriate conditions, and the research findings on which these parameters are based, to all practitioners in the state who diagnose or treat the medical condition.

Subd. 3. **Peer review.** The unit may require peer review by the Minnesota Medical Association, Minnesota Chiropractic Association or appropriate health licensing board for specific health care conditions for which practice in all or part of the state deviates from practice parameters. The commissioner may also require peer review by the Minnesota Medical Association, Minnesota Chiropractic Association or appropriate health licensing board for specific conditions for which there are large variations in treatment method or frequency of treatment in all or part of the state. Peer review may be required for all practitioners statewide, or limited to practitioners in specific areas of the state. The peer review must determine whether the procedures conducted by practitioners are necessary and appropriate, and within acceptable and prevailing practice parameters that have been disseminated by the health care analysis unit in conjunction with the appropriate professional organizations. If a practitioner continues to perform procedures that are inappropriate, even after educational efforts by the review panel, the practitioner may be reported to the appropriate professional licensing board.

Subd. 4. **Practice parameter advisory committee.** The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, but does not expire.

History: *1992 c 549 art 7 s 3*

62J.33 TECHNICAL ASSISTANCE FOR PURCHASERS.

The health care analysis unit shall provide technical assistance to health plan and health care purchasers. The unit shall collect information about:

(1) premiums, benefit levels, managed care procedures, health care outcomes, and other features of popular health plans and health carriers; and

(2) prices, outcomes, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses.

The commissioner shall publicize this information in an easily understandable format.

History: *1992 c 549 art 7 s 4*

62J.34 OUTCOME-BASED PRACTICE PARAMETERS.

Subdivision 1. **Practice parameters.** The health care analysis unit may develop, adopt, revise, and disseminate practice parameters, and disseminate research findings,

that are supported by medical literature and appropriately controlled studies to minimize unnecessary, unproven, or ineffective care. Among other appropriate activities relating to the development of practice parameters, the health care analysis unit shall:

(1) determine uniform specifications for the collection, transmission, and maintenance of health outcomes data; and

(2) conduct studies and research on the following subjects:

(i) new and revised practice parameters to be used in connection with state health care programs and other settings;

(ii) the comparative effectiveness of alternative modes of treatment, medical equipment, and drugs;

(iii) the relative satisfaction of participants with their care, determined with reference to both provider and mode of treatment;

(iv) the cost versus the effectiveness of health care treatments; and

(v) the impact on cost and effectiveness of health care of the management techniques and administrative interventions used in the state health care programs and other settings.

Subd. 2. **Approval.** The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission, may approve practice parameters that are endorsed, developed, or revised by the health care analysis unit. The commissioner is exempt from the rulemaking requirements of chapter 14 when approving practice parameters approved by the federal agency for health care policy and research, practice parameters adopted for use by a national medical society, or national medical specialty society. The commissioner shall use rulemaking to approve practice parameters that are newly developed or substantially revised by the health care analysis unit. Practice parameters adopted without rulemaking must be published in the State Register.

Subd. 3. **Medical malpractice cases.** (a) In an action against a provider for malpractice, error, mistake, or failure to cure, whether based in contract or tort, adherence to a practice parameter approved by the commissioner of health under subdivision 2 is an absolute defense against an allegation that the provider did not comply with accepted standards of practice in the community.

(b) Evidence of a departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense under paragraph (a).

(c) Paragraphs (a) and (b) apply to claims arising on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter, whichever is later.

(d) Nothing in this section changes the standard or burden of proof in an action alleging a delay in diagnosis, a misdiagnosis, inappropriate application of a practice parameter, failure to obtain informed consent, battery or other intentional tort, breach of contract, or product liability.

History: *1992 c 549 art 7 s 5*