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 MinnesotaCare act.

History: *1992 c 549 art 1 s 1; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

62J.016 GOALS OF RESTRUCTURING.

The state seeks to bring about changes in the health care delivery and financing system that will assure quality, affordable, and accessible health care for all Minnesotans. This goal will be accomplished by restructuring the delivery system, the financial incentives, and the regulatory environment in a way that will make health care providers and health plan companies more accountable to consumers, group purchasers, and communities for their costs and quality, their effectiveness in meeting the health care needs of all of their patients and enrollees, and their contributions to improving the health of the greater community.

History: *1994 c 625 art 1 s 1*

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system by July 1, 1997. The restructured system will have two options: (1) integrated service networks, which will be accountable for meeting state cost containment, quality, and access standards; or (2) a uniform set of price and utilization controls for all health care services for Minnesota residents not provided through an integrated service network. Both systems will operate under the state's growth limits and will be structured to promote competition in the health care marketplace.

Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community-based integrated service networks, and to reduce administrative costs by standardizing third-party billing forms and procedures and utilization review requirements. Voluntary formation of other integrated service networks will begin after rules have been adopted, but not before July 1, 1996. Statutes and rules for the entire restructured health care financing and delivery system must be enacted or adopted by January 1, 1996, and a phase-in of the all-payer reimbursement system must begin on that date. By July 1, 1997, all health coverage must be regulated under integrated service network or community integrated service network law pursuant to chapter 62N or all-payer law pursuant to chapter 62P.

History: *1994 c 625 art 1 s 2*

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, integrated service networks; community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; 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 or health care 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 and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

Subd. 9. **Safety.** "Safety" means a judgment of the acceptability of risk of using a technology in a specified situation.

Subd. 10. **Health plan company.** "Health plan company" means a health plan company as defined in section 62Q.01, subdivision 4.

History: *1992 c 549 art 1 s 2; 1993 c 345 art 3 s 1; art 4 s 1; art 6 s 1; 1994 c 625 art 8 s 14,15*

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

Subdivision 1. **Limits on the rate of growth.** (a) The commissioner of health shall set annual limits on the rate of growth of public and private spending on health care services for Minnesota residents, as provided in paragraph (b). The limits on growth must be set at levels the commissioner determines to be realistic and achievable but that will reduce the rate of growth in health care spending by at least ten percent per year for the next five years. The commissioner shall set limits on growth based on available data on spending and growth trends, including data from group purchasers, national data on public and private sector health care spending and cost trends, and trend information from other states.

(b) The commissioner shall set the following annual limits on the rate of growth of public and private spending on health care services for Minnesota residents:

(1) for calendar year 1994, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1993 plus 6.5 percentage points;

(2) for calendar year 1995, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1994 plus 5.3 percentage points;

(3) for calendar year 1996, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1995 plus 4.3 percentage points;

(4) for calendar year 1997, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1996 plus 3.4 percentage points; and

(5) for calendar year 1998, the rate of growth must not exceed the change in the regional consumer price index for urban consumers for calendar year 1997 plus 2.6 percentage points.

The commissioner shall adjust the growth limit set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993 to December 31, 1993. The commissioner shall publish:

(1) the projected limits in the State Register by April 15 of the year immediately preceding the year in which the limit will be effective except for the year 1993, in which the limit shall be published by July 1, 1993;

(2) the quarterly change in the regional consumer price index for urban consumers; and

(3) the health care financing administration forecast for total growth in the national health care expenditures. In setting an annual limit, the commissioner is exempt from the rulemaking requirements of chapter 14. The commissioner's decision on an annual limit is not appealable.

Subd. 1a. **Adjusted growth limits and enforcement.** (a) The commissioner shall publish the final adjusted growth limit in the State Register by January 31 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to reflect differences between the actual regional consumer price index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by February 15 of each year on differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy.

(b) The commissioner shall enforce limits on growth in spending and revenues for integrated service networks and for the regulated all-payer option. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the implementation of growth limits, the commissioner may adjust the base year

spending totals or growth limits or take other action to reverse the effect of the artificial inflation or padding.

(c) The commissioner shall impose and enforce overall limits on growth in revenues and spending for integrated service networks, with adjustments for changes in enrollment, benefits, severity, and risks. If an integrated service network exceeds the growth limits, the commissioner may reduce future limits on growth in aggregate premium revenues for that integrated service network by up to the amount overspent. If the integrated service network system exceeds a systemwide spending limit, the commissioner may reduce future limits on growth in premium revenues for the integrated service network system by up to the amount overspent.

(d) The commissioner shall set prices, utilization controls, and other requirements for the regulated all-payer option to ensure that the overall costs of this system, after adjusting for changes in population, severity, and risk, do not exceed the growth limits. If growth limits for a calendar year are exceeded, the commissioner may reduce reimbursement rates or otherwise recoup amounts exceeding the limit for all or part of the next calendar year. To the extent possible, the commissioner may reduce reimbursement rates or otherwise recoup amounts over the limit from individual providers who exceed the growth limits.

(e) The commissioner, in consultation with the Minnesota health care commission, shall research and make recommendations to the legislature regarding the implementation of growth limits for integrated service networks and the regulated all-payer option. The commissioner must consider both spending and revenue approaches and will report on the implementation of the interim limits as defined in sections 62P.04 and 62P.05. The commissioner must examine and make recommendations on the use of annual update factors based on volume performance standards as a mechanism for achieving controls on spending in the all-payer option. The commissioner must make recommendations regarding the enforcement mechanism and must consider mechanisms to adjust future growth limits as well as mechanisms to establish financial penalties for noncompliance. The commissioner must also address the feasibility of systemwide limits imposed on all integrated service networks.

(f) The commissioner shall report to the legislative commission on health care access by December 1, 1994, on trends in aggregate spending and premium revenue for health plan companies. The commissioner shall use data submitted under section 62P.04 and other available data to complete this report.

Subd. 2. [Renumbered 62J.35, subd. 1]

Subd. 2a. [Renumbered 62J.35, subd. 2]

Subd. 2b. [Renumbered 62J.35, subd. 3.]

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 but excluding Chisago, Isanti, Wright, and Sherburne counties, 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) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the

American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Health Care Financing Administration 1500 form, or other standardized forms or procedures;

(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 referral centers for specialized and high-cost procedures and treatment and establish minimum standards and requirements for particular procedures or treatment;

(10) within the limits of appropriations for these purposes, 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, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(11) administer the data analysis unit; 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.** When the law requires the commissioner of health to consult with the Minnesota health care commission when undertaking any of the duties required under this chapter and chapter 62N, the commissioner shall consult with the 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 commission on health care access of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative commission on health care access 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 commission on health care access at the earliest possible time.

Subd. 5. **Appeals.** A person aggrieved may appeal a decision made under this chapter through a contested case proceeding governed under chapter 14. The notice of appeal must be served on the commissioner within 30 days of receiving notice of the decision. The commissioner shall decide the contested case.

Subd. 6. **Rulemaking.** The commissioner shall adopt rules under chapter 14 to implement this chapter.

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 commissioner, 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 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.

Subd. 8. [Repealed, 1994 c 625 art 8 s 74]

Subd. 9. **Growth limits; federal programs.** The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk-based contracting with health plan companies that is consistent with statewide growth limits. The methodology shall be presented for review by the Minnesota health care commission and the legislative commission on health care access prior to the submission of a waiver request to the health care financing administration and subsequent implementation of the methodology.

History: *1992 c 549 art 1 s 3; 1993 c 247 art 1 s 1-6; 1993 c 345 art 1 s 1; art 3 s 2-4,18; art 5 s 7,8; art 6 s 2,3; 1994 c 625 art 8 s 16-18*

62J.045 MEDICAL EDUCATION AND RESEARCH COSTS.

Subdivision 1. **Purpose.** The legislature finds that all health care stakeholders, as well as society at large, benefit from medical education and health care research. The legislature further finds that the cost of medical education and research should not be borne by a few hospitals or medical centers but should be fairly allocated across the health care system.

Subd. 2. **Definition.** For purposes of this section, "health care research" means research that is not subsidized from private grants, donations, or other outside research sources but is funded by patient out-of-pocket expenses or a third party payer and has been approved by an institutional review board certified by the United States Department of Health and Human Services.

Subd. 3. **Cost allocation for education and research.** By January 1, 1994, the commissioner of health, in consultation with the health care commission and the health technology advisory committee, shall:

(1) develop mechanisms to gather data and to identify the annual cost of medical education and research conducted by hospitals, medical centers, or health maintenance organizations;

(2) determine a percentage of the annual rate of growth established under section 62J.04 to be allocated for the cost of education and research and develop a method to assess the percentage from each group purchaser;

(3) develop mechanisms to collect the assessment from group purchasers to be deposited in a separate education and research fund; and

(4) develop a method to allocate the education and research fund to specific health care providers.

History: *1993 c 345 art 3 s 5*

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 27 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 seven consumer members, including three members appointed by the governor, one of whom must represent persons over age 65; one member appointed by the consortium of citizens with disabilities to represent consumers with physical disabilities or chronic illness; one member appointed by the mental health association of Minnesota, in consultation with the Minnesota chapter of the society of Americans for recovery, to represent consumers with mental illness or chemical dependency; 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 activity 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. [Repealed, 1993 c 247 art 1 s 21]

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.

Subd. 9. **Repealer.** This section is repealed effective July 1, 1996.

History: *1992 c 549 art 1 s 4; 1993 c 345 art 6 s 4; 1994 c 625 art 8 s 19*

62J.051 DISTRIBUTION OF HEALTH CARE TECHNOLOGY, FACILITIES, AND FUNCTIONS; PUBLIC FORUMS.

The commission may promote and facilitate an open, voluntary, nonregulatory, and public process for regional and statewide discussion regarding the appropriate distribution of health care technologies, facilities, and functions. The process must include the participation of consumers, employers and other group purchasers, providers, health plan companies, and the health care technology industry. The commission shall ensure opportunities for broad-based public input from other interested persons and organizations as well. The purpose of the process is to create an open public forum with the goal of facilitating collaboration for the distribution of a particular technology, facility, or function to achieve health reform goals. Participation in the forums is voluntary and agreements or distribution plans that may be recommended through this process are not mandatory or binding on any person or organization. The recommendations may be considered by the commissioner of health for purposes of the antitrust exception process under sections 62J.2911 to 62J.2921, and the process for

reviewing major spending commitments under section 62J.17, but are not binding on the commissioner. The commission may develop criteria for selecting specific technologies, facilities, and functions for discussion and may establish procedures and ground rules for discussion and the development of recommended agreements or distribution plans. The commission may appoint advisory committees to facilitate discussion and planning and may request that regional coordinating boards serve as or convene regional public forums.

History: *1994 c 625 art 8 s 20*

62J.06 IMMUNITY FROM LIABILITY.

No member of the Minnesota health care commission established under section 62J.05, regional coordinating boards established under section 62J.09, health planning advisory committee established under section 62J.15, data collection advisory committee established under section 62J.30, or practice parameter advisory committee established under section 62J.32 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.

History: *1993 c 247 art 1 s 7*

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 MinnesotaCare 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 MinnesotaCare 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 MinnesotaCare 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; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

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 approve 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. 1a. **Duties related to cost containment.** (a) **Allocation of regional spending limits.** Regional coordinating boards may advise the commissioner regarding allocation of annual regional limits on the rate of growth for providers in the regulated all-payer option in order to:

(1) achieve communitywide and regional public health goals consistent with those established by the commissioner; and

(2) promote access to and equitable reimbursement of preventive and primary care providers.

(b) **Technical assistance.** Regional coordinating boards, in cooperation with the commissioner, shall provide technical assistance to parties interested in establishing or operating a community integrated service network or integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23.

Subd. 2. **Membership.** (a) **Number of members.** Each regional coordinating board consists of 17 members as provided in this subdivision. A member may designate a representative to act as a member of the board in the member's absence. The governor shall appoint the chair of each regional board from among its members. The appointing authorities under each paragraph for which there is to be chosen more than one member shall consult prior to appointments being made to ensure that, to the extent possible, the board includes a representative from each county within the region.

(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 four 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 mem-

ber 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 appointed by the Minnesota chamber of commerce from nominations provided by 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. [Repealed, 1993 c 247 art 1 s 21]

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 vote in regional coordinating 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 regional coordinating board's proceedings other than as an individual consumer of health care services. A member with a direct financial interest may participate in the proceedings, without voting, provided that the member discloses any direct financial interest to the regional coordinating board at the beginning of the proceedings.

Subd. 6. **Technical assistance.** The commissioner shall provide technical assistance to regional coordinating boards.

Subd. 6a. **Contracting.** The commissioner, at the request of a regional coordinating board, may contract on behalf of the board with an appropriate regional organization to provide staff support to the board, in order to assist the board in carrying out the duties assigned in this section.

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, 1996.

History: *1992 c 549 art 1 s 6; 1992 c 603 s 28; 1993 c 247 art 1 s 8-10; 1993 c 345 art 3 s 6; art 6 s 5-8; 1994 c 625 art 3 s 22; art 8 s 21,22*

62J.15 HEALTH PLANNING.

Subdivision 1. **Health technology advisory committee.** The Minnesota health care commission shall convene an advisory committee to conduct evaluations of existing research and technology assessments conducted by other entities of new and existing health care technologies. 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 include high-cost drugs, devices, procedures, or processes

applied to human health care, such as high-cost transplants and expensive scanners and imagers. The advisory committee is governed by section 15.0575, subdivision 3, except that members do not receive per diem payments.

Subd. 1a. **Definition.** For purposes of sections 62J.15 to 62J.156, the terms "evaluate," "evaluation," and "evaluating" mean the review or reviewing of research and technology assessments conducted by other entities relating to specific technologies and their specific use and application.

Subd. 2. [Repealed, 1993 c 345 art 4 s 7]

History: *1992 c 549 art 1 s 7; 1993 c 247 art 1 s 11; 1993 c 345 art 4 s 2,3; 1994 c 465 art 3 s 66*

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

Subdivision 1. **Generally.** The health technology advisory committee established in section 62J.15 shall:

(1) develop criteria and processes for evaluating health care technology assessments made by other entities;

(2) conduct evaluations of specific technologies and their specific use and application;

(3) report the results of the evaluations to the commissioner and the Minnesota health care commission; and

(4) carry out other duties relating to health technology assigned by the commission.

Subd. 2. **Priorities for designating technologies for assessment.** The health technology advisory committee shall consider the following criteria in designating technologies for evaluation:

(1) the level of controversy within the medical or scientific community, including questionable or undetermined efficacy;

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

(6) the impact on patient safety and health outcome;

(7) the public health importance;

(8) the level of public and professional demand;

(9) the social, ethical, and legal concerns; and

(10) the prevalence of the disease or condition.

The committee may give different weights or attach different importance to each of the criteria, depending on the technology being considered. The committee shall consider any additional criteria approved by the commissioner and the Minnesota health care commission.

Subd. 3. **Criteria for evaluating technology.** In developing the criteria for evaluating specific technologies, the health technology advisory committee shall consider safety, improvement in health outcomes, and the degree to which a technology is clinically effective and cost-effective, and other factors.

Subd. 4. **Technology evaluation process.** (a) The health technology advisory committee shall collect and evaluate studies and research findings on the technologies selected for evaluation from as wide of a range of sources as needed, including, but not limited to: federal agencies or other units of government, international organizations conducting health care technology assessments, health carriers, insurers, manufacturers, professional and trade associations, nonprofit organizations, and academic institutions. The health technology advisory committee may use consultants or experts and solicit testimony or other input as needed to evaluate a specific technology.

(b) When the evaluation process on a specific technology has been completed, the

health technology advisory committee shall submit a preliminary report to the health care commission and publish a summary of the preliminary report in the State Register with a notice that written comments may be submitted. The preliminary report must include the results of the technology assessment evaluation, studies and research findings considered in conducting the evaluation, and the health technology advisory committee's summary statement about the evaluation. Any interested persons or organizations may submit to the health technology advisory committee written comments regarding the technology evaluation within 30 days from the date the preliminary report was published in the State Register. The health technology advisory committee's final report on its technology evaluation must be submitted to the health care commission. A summary of written comments received by the health technology advisory committee within the 30-day period must be included in the final report. The health care commission shall review the final report and prepare its comments and recommendations. Before completing its final comments and recommendations, the health care commission shall provide adequate public notice that testimony will be accepted by the health care commission. The health care commission shall then forward the final report, its comments and recommendations, and a summary of the public's comments to the commissioner and information clearinghouse.

(c) The reports of the health technology advisory committee and the comments and recommendations of the health care commission should not eliminate or bar new technology, and are not rules as defined in the administrative procedure act.

Subd. 5. **Use of technology evaluation.** (a) The final report on the technology evaluation and the commission's comments and recommendations may be used:

(1) by the commissioner in retrospective and prospective review of major expenditures;

(2) by integrated service networks and other group purchasers and by employers, in making coverage, contracting, purchasing, and reimbursement decisions;

(3) by government programs and regulators of the regulated all-payer option, in making coverage, contracting, purchasing, and reimbursement decisions;

(4) by the commissioner and other organizations in the development of practice parameters;

(5) by health care providers in making decisions about adding or replacing technology and the appropriate use of technology;

(6) by consumers in making decisions about treatment;

(7) by medical device manufacturers in developing and marketing new technologies; and

(8) as otherwise needed by health care providers, health care plans, consumers, and purchasers.

(b) At the request of the commissioner, the health care commission, in consultation with the health technology advisory committee, shall submit specific recommendations relating to technologies that have been evaluated under this section for purposes of retrospective and prospective review of major expenditures and coverage, contracting, purchasing, and reimbursement decisions affecting state programs and the all-payer option.

Subd. 6. **Application to the regulated all-payer option.** The health technology advisory committee shall recommend to the Minnesota health care commission and the commissioner methods to control the diffusion and use of technology within the regulated all-payer option for services provided outside of an integrated service network.

Subd. 7. **Data gathering.** In evaluating a specific technology, the health technology advisory committee may seek the use of data collected by manufacturers, health plans, professional and trade associations, nonprofit organizations, academic institutions, or any other organization or association that may have data relevant to the committee's technology evaluation. All information obtained under this subdivision shall be considered nonpublic data under section 13.02, subdivision 9, unless the data is already available to the public generally or upon request.

History: *1993 c 345 art 4 s 4; 1994 c 625 art 3 s 22*

62J.156 CLOSED COMMITTEE HEARINGS.

Notwithstanding section 471.705, the health technology advisory committee may meet in closed session to discuss a specific technology or procedure that involves data received under section 62J.152, subdivision 7, that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

History: *1993 c 345 art 4 s 5*

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) **Access.** "Access" has the meaning given in section 62J.2912, subdivision 2.

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

(c) **Cost.** "Cost" means the amount paid by consumers or third party payers for health care services or products.

(d) **Date of the major spending commitment.** "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.

(e) **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.

(f) **Major spending commitment.** "Major spending commitment" means an expenditure in excess of $500,000 for:

(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.

(g) **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.

(h) **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.

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. [Repealed, 1993 c 345 art 6 s 26]

Subd. 4a. **Expenditure reporting.** (a) **General requirement.** A provider making a major spending commitment after April 1, 1992, shall submit notification of the expenditure to the commissioner and provide the commissioner with any relevant background information.

(b) **Report.** Notification must include a report, submitted within 60 days after the date of the major spending commitment, using terms conforming to the definitions in section 62J.03 and this section. Each report is subject to retrospective review and must contain:

(1) a detailed description of the major spending commitment and its purpose;

(2) the date of the major spending commitment;

(3) a statement of the expected impact that the major spending commitment will have on charges by the provider to patients and third party payers;

(4) a statement of the expected impact on the clinical effectiveness or quality of care received by the patients that the provider expects to serve;

(5) a statement of the extent to which equivalent services or technology are already available to the provider's actual and potential patient population;

(6) a statement of the distance from which the nearest equivalent services or technology are already available to the provider's actual and potential population;

(7) a statement describing the pursuit of any lawful collaborative arrangements; and

(8) a statement of assurance that the provider will not use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective, unless the technology is used for experimental or research purposes to determine whether a technology or procedure is clinically effective and cost-effective.

The provider may submit any additional information that it deems relevant.

(c) **Additional information.** The commissioner may request additional information from a provider for the purpose of review of a report submitted by that provider, and may consider relevant information from other sources. A provider shall provide any information requested by the commissioner within the time period stated in the request, or within 30 days after the date of the request if the request does not state a time.

(d) **Failure to comply.** If the provider fails to submit a complete and timely expenditure report, including any additional information requested by the commissioner, the commissioner may make the provider's subsequent major spending commitments subject to the procedures of prospective review and approval under subdivision 6a.

Subd. 5. [Repealed, 1993 c 345 art 6 s 26]

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review. The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Subd. 6. [Repealed, 1993 c 345 art 6 s 26]

Subd. 6a. **Prospective review and approval.** (a) **Requirement.** No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) **Application.** A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under paragraph (d). The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) **Review.** The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under paragraph (d). In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the

Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

(d) **Exceptions.** The prospective review and approval process 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.

(e) **Notification required for excepted major spending commitment.** A provider making a major spending commitment covered by paragraph (d) shall provide notification of the major spending commitment as provided under subdivision 4a.

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

History: *1992 c 549 art 1 s 8; 1993 c 345 art 6 s 9-12*

NOTE: Subdivision 2, paragraph (f), was also amended by Laws 1993, chapter 247, article 1, section 12, to read as follows.

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

NOTE: Subdivisions 4, 5, and 6, were also amended by Laws 1993, chapter 247, article 1, sections 13, 14, and 15, to read as follows:

"Subd. 4. **Expenditure reporting.** Any provider 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 within 60 days of making the major spending commitment 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 boards 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; or in the event providers have failed to pursue lawful 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) **Penalties and remedies.** The commissioner of health shall have the authority to issue fines, seek injunctions, and pursue other remedies as provided by law."

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.

History: *1992 c 549 art 1 s 9; 1992 c 603 s 29; 1993 c 247 art 1 s 16*

62J.21 [Repealed, 1993 c 247 art 1 s 21]

62J.212 COLLABORATION ON PUBLIC HEALTH GOALS.

The commissioner may increase regional spending limits if public health goals for that region are achieved.

History: *1993 c 345 art 5 s 9*

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 person benefits financially by referring a patient to another person, recommending another person, 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 persons in the state, regardless of whether the person participates in any state health care program. The commissioner shall approve a transition plan submitted to the commissioner by January 1, 1993, by a person who is in violation of this section that provides a reasonable time for the person to modify prohibited practices or divest financial interests in other persons in order to come into compliance with this section. Transition plans that identify individuals are private data. Transition plans that do not identify individuals are nonpublic data.

Subd. 3. **Penalty.** The commissioner may assess a fine against a person who violates this section. The amount of the fine is $1,000 or 110 percent of the estimated financial benefit that the person realized as a result of the prohibited financial arrangement or payment relationship, whichever is greater. A person 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.

Subd. 4. **Chapter 62N networks.** (a) The legislature finds that the formation and operation of integrated service networks and community integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of integrated service networks and community integrated service networks. The legislature finds that the federal Medicare antikickback laws should not be interpreted to interfere with the development of integrated service networks or community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

(b) An arrangement between an integrated service network or a community integrated service network and any or all of its participating entities is not subject to liability under subdivisions 1 and 2.

History: *1992 c 549 art 1 s 12; 1993 c 247 art 1 s 17; 1993 c 345 art 6 s 13; 1994 c 625 art 8 s 23*

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 [Repealed, 1993 c 345 art 6 s 26]

NOTE: Subdivisions 1 and 4 were also amended by Laws 1993, chapter 247, sections 18 and 19, to read as follows:

"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 may 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, and that this approval will make relationships immune from state and federal antitrust liability.

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 commissioner is an absolute defense against any action under state antitrust laws."

ANTITRUST EXCEPTIONS

62J.2911 ANTITRUST EXCEPTIONS; 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 cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of sections 62J.2911 to 62J.2921 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 marketplace. The legislature intends that approval of arrangements be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that an arrangement approved by the commissioner and accompanied by such appropriate conditions, supervision, and regulation shall not be subject to state and federal antitrust liability.

History: *1993 c 345 art 6 s 14*

62J.2912 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 62J.2911 to 62J.2921, the terms defined in this section have the meanings given them.

Subd. 2. **Access.** "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

Subd. 3. **Applicant.** "Applicant" means the party or parties to an agreement or business arrangement for which the commissioner's approval is sought under this section.

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

Subd. 5. **Contested case.** "Contested case" means a proceeding conducted by the office of administrative hearings under sections 14.57 to 14.62.

Subd. 6. **Cost or cost of health care.** "Cost" or "cost of health care" means the amount paid by consumers or third party payers for health care services or products.

Subd. 7. **Criteria.** "Criteria" means the cost, access, and quality of health care.

Subd. 8. **Health care products.** "Health care products" means durable medical equipment and "medical equipment" as defined in section 62J.17, subdivision 2, paragraph (g).

Subd. 9. **Health care service.** "Health care service" has the meaning given in section 62J.17, subdivision 2, paragraph (e).

Subd. 10. **Person.** "Person" means an individual or legal entity.

History: *1993 c 345 art 6 s 15*

62J.2913 SCOPE.

Subdivision 1. **Availability of exception.** Providers or purchasers wishing to engage in contracts, business or financial arrangements, or other activities, practices, or arrangements 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 may apply to the commissioner for an exception.

Subd. 2. **Absolute defense.** Approval by the commissioner is an absolute defense against any action under state and federal antitrust laws, except as provided under section 62J.2921, subdivision 5.

Subd. 3. **Application cannot be used to impose liability.** The commissioner may ask the attorney general to comment on an application. The application and any informa-

tion obtained by the commissioner under sections 62J.2914 to 62J.2916 that is not otherwise available is not admissible in any civil or criminal proceeding brought by the attorney general or any other person based on an antitrust claim, except:

(1) a proceeding brought under section 62J.2921, subdivision 5, based on an applicant's failure to substantially comply with the terms of the application; or

(2) a proceeding based on actions taken by the applicant prior to submitting the application, where such actions are admitted to in the application.

Subd. 4. **Out-of-state applicants.** Providers or purchasers not physically located in Minnesota are eligible to seek an exception for arrangements in which they transact business in Minnesota as defined in section 295.51.

History: *1993 c 345 art 6 s 16*

62J.2914 APPLICATION.

Subdivision 1. **Disclosure.** An application for approval must include, to the extent applicable, disclosure of the following:

(1) a descriptive title;

(2) a table of contents;

(3) exact names of each party to the application and the address of the principal business office of each party;

(4) the name, address, and telephone number of the persons authorized to receive notices and communications with respect to the application;

(5) a verified statement by a responsible officer of each party to the application attesting to the accuracy and completeness of the enclosed information;

(6) background information relating to the proposed arrangement, including:

(i) a description of the proposed arrangement, including a list of any services or products that are the subject of the proposed arrangement;

(ii) an identification of any tangential services or products associated with the services or products that are the subject of the proposed arrangement;

(iii) a description of the geographic territory involved in the proposed arrangement;

(iv) if the geographic territory described in item (iii), is different from the territory in which the applicants have engaged in the type of business at issue over the last five years, a description of how and why the geographic territory differs;

(v) identification of all products or services that a substantial share of consumers would consider substitutes for any service or product that is the subject of the proposed arrangement;

(vi) identification of whether any services or products of the proposed arrangement are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item (iii);

(vii) identification of the steps necessary, under current market and regulatory conditions, for other parties to enter the territory described in item (iii) and compete with the applicant;

(viii) a description of the previous history of dealings between the parties to the application;

(ix) a detailed explanation of the projected effects, including expected volume, change in price, and increased revenue, of the arrangement on each party's current businesses, both generally as well as the aspects of the business directly involved in the proposed arrangement;

(x) the present market share of the parties to the application and of others affected by the proposed arrangement, and projected market shares after implementation of the proposed arrangement;

(xi) a statement of why the projected levels of cost, access, or quality could not be achieved in the existing market without the proposed arrangement; and

(xii) an explanation of how the arrangement relates to any Minnesota health care commission or applicable regional coordinating board plans for delivery of health care; and

(7) a detailed explanation of how the transaction will affect cost, access, and quality. The explanation must address the factors in section 62J.2917, subdivision 2, paragraphs (b) to (d), to the extent applicable.

Subd. 2. **State Register notice.** In addition to the disclosures required in subdivision 1, the application must contain a written description of the proposed arrangement for purposes of publication in the State Register. The notice must include sufficient information to advise the public of the nature of the proposed arrangement and to enable the public to provide meaningful comments concerning the expected results of the arrangement. The notice must also state that any person may provide written comments to the commissioner, with a copy to the applicant, within 20 days of the notice's publication. The commissioner shall approve the notice before publication. If the commissioner determines that the submitted notice does not provide sufficient information, the commissioner may amend the notice before publication and may consult with the applicant in preparing the amended notice. The commissioner shall not publish an amended notice without the applicant's approval.

Subd. 3. **Multiple parties to a proposed arrangement.** For a proposed arrangement involving multiple parties, one joint application must be submitted on behalf of all parties to the arrangement.

Subd. 4. **Filing fee.** An application must be accompanied by a filing fee, which must be deposited in the health care access fund. The total of the deposited application fees is appropriated annually to the commissioner to administer the antitrust exceptions program. The filing fee is $1,000 for any application submitted by parties whose combined gross revenues exceeded $20,000,000 in the most recent calendar or fiscal year for which such figures are available. The filing fee for all other applications is $250.

Subd. 5. **Trade secret information; protection.** Trade secret information, as defined in section 13.37, subdivision 1, paragraph (b), must be protected to the extent required under chapter 13.

Subd. 6. **Commissioner's authority to refuse to review.** (a) If the commissioner determines that an application is unclear, incomplete, or provides an insufficient basis on which to base a decision, the commissioner may return the application. The applicant may complete or revise the application and resubmit it.

(b) If, upon review of the application and upon advice from the attorney general, the commissioner concludes that the proposed arrangement does not present any potential for liability under the state or federal antitrust laws, the commissioner may decline to review the application and so notify the applicant.

(c) The commissioner may decline to review any application relating to arrangements already in effect before the submission of the application. However, the commissioner shall review any application if the review is expressly provided for in a settlement agreement entered into before May 24, 1993, by the applicant and the attorney general.

Subd. 7. **Commissioner's authority to extend time limit.** Upon the showing of good cause, the commissioner may extend any of the time limits stated in sections 62J.2915 and 62J.2916 at the request of the applicant or another person.

History: *1993 c 345 art 6 s 17*

62J.2915 NOTICE AND COMMENT.

Subdivision 1. **Notice.** The commissioner shall cause the notice described in section 62J.2914, subdivision 2, to be published in the State Register and sent to the Minnesota health care commission, the regional coordinating boards for any regions that include all or part of the territory covered by the proposed arrangement, and any person who has requested to be placed on a list to receive notice of applications. The commissioner may maintain separate notice lists for different regions of the state. The commis-

sioner may also send a copy of the notice to any person together with a request that the person comment as provided under subdivision 2. Copies of the request must be provided to the applicant.

Subd. 2. **Comments.** Within 20 days after the notice is published, any person may mail to the commissioner written comments with respect to the application. Within 30 days after the notice is published, the Minnesota health care commission or any regional coordinating board may mail to the commissioner comments with respect to the application. Persons submitting comments shall provide a copy of the comments to the applicant. The applicant may mail to the commissioner written responses to any comments within ten days after the deadline for mailing such comments. The applicant shall send a copy of the response to the person submitting the comment.

History: *1993 c 345 art 6 s 18*

62J.2916 PROCEDURE FOR REVIEW OF APPLICATIONS.

Subdivision 1. **Choice of procedures.** After the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall select one of the three procedures provided in subdivision 2. In determining which procedure to use, the commissioner shall consider the following criteria:

(1) the size of the proposed arrangement, in terms of number of parties and amount of money involved;

(2) the complexity of the proposed arrangement;

(3) the novelty of the proposed arrangement;

(4) the substance and quantity of the comments received;

(5) any comments received from the Minnesota health care commission or regional coordinating boards; and

(6) the presence or absence of any significant gaps in the factual record.

If the applicant demands a contested case hearing no later than the conclusion of the period provided in section 62J.2915, subdivision 2, for the applicant to respond to comments, the commissioner shall not select a procedure. Instead, the applicant shall be given a contested case proceeding as a matter of right.

Subd. 2. **Procedures available.** (a) **Decision on the written record.** The commissioner may issue a decision based on the application, the comments, and the applicant's responses to the comments, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

(b) **Limited hearing.** (1) The commissioner may order a limited hearing. A copy of the order must be mailed to the applicant and to all persons who have submitted comments or requested to be kept informed of the proceedings involving the application. The order must state the date, time, and location of the limited hearing and must identify specific issues to be addressed at the limited hearing. The issues may include the feasibility and desirability of one or more alternatives to the proposed arrangement. The order must require the applicant to submit written evidence, in the form of affidavits and supporting documents, addressing the issues identified, within 20 days after the date of the order. The order shall also state that any person may arrange to receive a copy of the written evidence from the commissioner, at the person's expense, and may provide written comments on the evidence within 40 days after the date of the order. A person providing written comments shall provide a copy of the comments to the applicant.

(2) The limited hearing must be held before the commissioner or department of health staff member or members designated by the commissioner. The commissioner or the commissioner's designee or designees shall question the applicant about the evidence submitted by the applicant. The questions may address relevant issues identified in the comments submitted in response to the written evidence or identified by department of health staff or brought to light by department of health data. At the conclusion

of the applicant's responses to the questions, any person who submitted comments about the applicant's written evidence may make a statement addressing the applicant's responses to the questions. The commissioner or the commissioner's designee or designees may ask questions of any person making a statement. At the conclusion of all statements, the applicant may make a closing statement.

(3) The commissioner's decision after a limited hearing must be based upon the application, the comments, the applicant's response to the comments, the applicant's written evidence, the comments in response to the written evidence, and the information presented at the limited hearing, to the extent each is relevant. In making the decision, the commissioner may consult with staff of the department of health and may rely on department of health data.

(c) **Contested case hearing.** The commissioner may order a contested case hearing. A contested case hearing shall be tried before an administrative law judge who shall issue a written recommendation to the commissioner and shall follow the procedures in sections 14.57 to 14.62. All factual issues relevant to a decision must be presented in the contested case. The attorney general may appear as a party. Additional parties may appear to the extent permitted under sections 14.57 to 14.62. The record in the contested case includes the application, the comments, the applicant's response to the comments, and any other evidence that is part of the record under sections 14.57 to 14.62.

History: *1993 c 345 art 6 s 19; 1994 c 625 art 8 s 24*

62J.2917 CRITERIA FOR DECISION.

Subdivision 1. **Criteria.** The commissioner shall not approve an application unless the commissioner determines that the arrangement is more likely to result in lower costs, increased access, or increased quality of health care, than would otherwise occur under existing market conditions or conditions likely to develop without an exemption from state and federal antitrust law. In the event that a proposed arrangement appears likely to improve one or two of the criteria at the expense of another one or two of the criteria, the commissioner shall not approve the application unless the commissioner determines that the proposed arrangement, taken as a whole, is likely to substantially further the purpose of this chapter. In making such a determination, the commissioner may employ a cost/benefit analysis.

Subd. 2. **Factors.** (a) **Generally applicable factors.** In making a determination about cost, access, and quality, the commissioner may consider the following factors, to the extent relevant:

(1) whether the proposal is compatible with the cost containment plan or other plan of the Minnesota health care commission or the applicable regional plans of the regional coordinating boards;

(2) market structure:

(i) actual and potential sellers and buyers, or providers and purchasers;

(ii) actual and potential consumers;

(iii) geographic market area; and

(iv) entry conditions;

(3) current market conditions;

(4) the historical behavior of the market;

(5) performance of other, similar arrangements;

(6) whether the proposal unnecessarily restrains competition or restrains competition in ways not reasonably related to the purposes of this chapter; and

(7) the financial condition of the applicant.

(b) **Cost.** The commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an

application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payers; the applicants do not have the burden of proving that third party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third party payers. In making determinations as to costs, the commissioner may consider:

(1) the cost savings likely to result to the applicant;

(2) the extent to which the cost savings are likely to be passed on to the consumer and in what form;

(3) the extent to which the proposed arrangement is likely to result in cost shifting by the applicant onto other payers or purchasers of other products or services;

(4) the extent to which the cost shifting by the applicant is likely to be followed by other persons in the market;

(5) the current and anticipated supply and demand for any products or services at issue;

(6) the representations and guarantees of the applicant and their enforceability;

(7) likely effectiveness of regulation by the commissioner;

(8) inferences to be drawn from market structure;

(9) the cost of regulation, both for the state and for the applicant; and

(10) any other factors tending to show that the proposed arrangement is or is not likely to reduce cost.

(c) **Access.** In making determinations as to access, the commissioner may consider:

(1) the extent to which the utilization of needed health care services or products by the intended targeted population is likely to increase or decrease. When a proposed arrangement is likely to increase access in one geographic area, by lowering prices or otherwise expanding supply, but limits access in another geographic area by removing service capabilities from that second area, the commissioner shall articulate the criteria employed to balance these effects;

(2) the extent to which the proposed arrangement is likely to make available a new and needed service or product to a certain geographic area; and

(3) the extent to which the proposed arrangement is likely to otherwise make health care services or products more financially or geographically available to persons who need them.

If the commissioner determines that the proposed arrangement is likely to increase access and bases that determination on a projected increase in utilization, the commissioner shall also determine and make a specific finding that the increased utilization does not reflect overutilization.

(d) **Quality.** In making determinations as to quality, the commissioner may consider the extent to which the proposed arrangement is likely to:

(1) decrease morbidity and mortality;

(2) result in faster convalescence;

(3) result in fewer hospital days;

(4) permit providers to attain needed experience or frequency of treatment, likely to lead to better outcomes;

(5) increase patient satisfaction; and

(6) have any other features likely to improve or reduce the quality of health care.

History: *1993 c 345 art 6 s 20*

62J.2918 DECISION.

Subdivision 1. **Approval or disapproval.** The commissioner shall issue a written

decision approving or disapproving the application. The commissioner may condition approval on a modification of all or part of the proposed arrangement to eliminate any restriction on competition that is not reasonably related to the goals of reducing cost or improving access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state.

Subd. 2. **Findings of fact.** The commissioner's decision shall make specific findings of fact concerning the cost, access, and quality criteria, and identify one or more of those criteria as the basis for the decision.

Subd. 3. **Data for supervision.** A decision approving an application must require the periodic submission of specific data relating to cost, access, and quality, and to the extent feasible, identify objective standards of cost, access, and quality by which the success of the arrangement will be measured. However, if the commissioner determines that the scope of a particular proposed arrangement is such that the arrangement is certain to have neither a positive or negative impact on one or two of the criteria, the commissioner's decision need not require the submission of data or establish an objective standard relating to those criteria.

History: *1993 c 345 art 6 s 21*

62J.2919 APPEAL.

After the commissioner has rendered a decision, the applicant or any other person aggrieved may appeal the decision to the Minnesota court of appeals within 30 days after receipt of the commissioner's decision. The appeal is governed by sections 14.63 to 14.69. The appellate process does not include a contested case under sections 14.57 to 14.62. The commissioner's determination, under section 62J.2916, subdivision 1, of which procedure to use may not be raised as an issue on appeal.

History: *1993 c 345 art 6 s 22*

62J.2920 SUPERVISION AFTER APPROVAL.

Subdivision 1. **Appropriate supervision.** The commissioner shall appropriately supervise, monitor, and regulate approved arrangements.

Subd. 2. **Procedures.** The commissioner shall review data submitted periodically by the applicant. The commissioner's order shall set forth the time schedule for the submission of data, which shall be at least once a year. The commissioner's order must identify the data that must be submitted, although the commissioner may subsequently require the submission of additional data or alter the time schedule. Upon review of the data submitted, the commissioner shall notify the applicant of whether the arrangement is in compliance with the commissioner's order. If the arrangement is not in compliance with the commissioner's order, the commissioner shall identify those respects in which the arrangement does not conform to the commissioner's order.

An applicant receiving notification that an arrangement is not in compliance has 30 days in which to respond with additional data. The response may include a proposal and a time schedule by which the applicant will bring the arrangement into compliance with the commissioner's order. If the arrangement is not in compliance and the commissioner and the applicant cannot agree to the terms of bringing the arrangement into compliance, the matter shall be set for a contested case hearing.

The commissioner shall publish notice in the State Register two years after the date of an order approving an application, and at two-year intervals thereafter, soliciting comments from the public concerning the impact that the arrangement has had on cost, access, and quality. The commissioner may request additional oral or written information from the applicant or from any other source.

Subd. 3. **Study.** The commissioner shall study and make recommendations by January 15, 1995, on the appropriate length and scope of supervision of arrangements approved for exemption from the antitrust laws.

History: *1993 c 345 art 6 s 23*

62J.2921 REVOCATION.

Subdivision 1. **Conditions.** The commissioner may revoke approval of a cooperative arrangement only if:

(1) the arrangement is not in substantial compliance with the terms of the application;

(2) the arrangement is not in substantial compliance with the conditions of approval;

(3) the arrangement has not and is not likely to substantially achieve the improvements in cost, access, or quality identified in the approval order as the basis for the commissioner's approval of the arrangement; or

(4) the conditions in the marketplace have changed to such an extent that competition would promote reductions in cost and improvements in access and quality better than does the arrangement at issue. In order to revoke on the basis that conditions in the marketplace have changed, the commissioner's order must identify specific changes in the marketplace and articulate why those changes warrant revocation.

Subd. 2. **Notice.** The commissioner shall begin a proceeding to revoke approval by providing written notice to the applicant describing in detail the basis for the proposed revocation. Notice of the proceeding must be published in the State Register and submitted to the Minnesota health care commission and the applicable regional coordinating boards. The notice must invite the submission of comments to the commissioner.

Subd. 3. **Procedure.** A proceeding to revoke an approval must be conducted as a contested case proceeding upon the written request of the applicant. Decisions of the commissioner in a proceeding to revoke approval are subject to judicial review under sections 14.63 to 14.69.

Subd. 4. **Alternatives to revocation preferred.** In deciding whether to revoke an approval, the commissioner shall take into account the hardship that the revocation may impose on the applicant and any potential disruption of the market as a whole. The commissioner shall not revoke an approval if the arrangement can be modified, restructured, or regulated so as to remedy the problem upon which the revocation proceeding is based. The applicant may submit proposals for alternatives to revocation. Before approving an alternative to revocation that involves modifying or restructuring an arrangement, the commissioner shall publish notice in the State Register that any person may comment on the proposed modification or restructuring within 20 days after publication of the notice. The commissioner shall not approve the modification or restructuring until the comment period has concluded. An approved modified or restructured arrangement is subject to appropriate supervision under section 62J.2920.

Subd. 5. **Impact of revocation.** An applicant that has had its approval revoked is not required to terminate the arrangement. The applicant cannot be held liable under state or federal antitrust law for acts that occurred while the approval was in effect, except to the extent that the applicant failed to substantially comply with the terms of its application or failed to substantially comply with the terms of the approval. The applicant is fully subject to state and federal antitrust law after the revocation becomes effective and may be held liable for acts that occur after the revocation.

History: *1993 c 345 art 6 s 24*

DATA COLLECTION AND RESEARCH INITIATIVES

62J.30 DATA 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 or that has been approved by the federal

agency for health care policy and research or adopted for use by the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, or a board approved by the American Dental Association.

(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 data 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 data analysis unit, shall:

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

(2) establish the condition-specific database 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 data 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, to the extent feasible, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative database 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 data analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden them. The unit may require health care providers and health carriers to collect and provide all patient health records and claim files, and cooperate in other ways with the data collection process. The unit may also require health care providers and health carriers to provide mailing lists of patients who have consented to release of data. The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plans when reporting data under this chapter. The data analysis unit must code patient identifiers to prevent identification and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and section 144.335.

Subd. 7. **Data classification.** (a) Data collected through the large-scale database initiatives of the data analysis unit required by section 62J.31 that identify individual patients or providers 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. The commissioner shall require any person or organization receiving under this subdivision either private data on individuals or nonpublic data to sign an agreement to maintain the data that it receives according to the statutory provisions applicable to the data. The agreement shall not limit the preparation and dissemination of summary data as permitted under section 13.05, subdivision 7. To the extent reasonably possible, release of private, confidential, or nonpublic data under this chapter shall be made without releasing data that identifies patients and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale database initiatives of the data 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 data analysis unit.

Subd. 8. **Data collection advisory committee.** (a) 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, except that its existence does not terminate and members do not receive per diem compensation.

(b) The data collection advisory committee shall develop a timeline to complete all responsibilities and transfer any ongoing responsibilities to the data institute. The timeline must specify the data on which ongoing responsibilities will be transferred. This transfer must be completed by July 1, 1994.

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 data 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 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; 1993 c 247 art 5 s 1-4; 1993 c 345 art 3 s 18; art 12 s 1-4*

62J.31 LARGE-SCALE DATABASE.

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

Subd. 2. **Specific health conditions.** (a) Data collected under this section must be collected for specific health conditions, rather than specific procedures, types of health care providers, or services. The data 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, as provided in section 62J.30, subdivisions 6 and 7. 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 data 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 databases.** (a) The data 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 database established by the unit and existing private sector databases and

shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

(b) The data analysis unit shall use existing public sector databases, such as those existing for medical assistance and Medicare, to the greatest extent possible. The unit shall establish linkages between existing public sector databases 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; 1993 c 247 art 5 s 5,6; 1993 c 345 art 3 s 18*

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

Subdivision 1. **Data analysis.** The data analysis unit shall analyze the data collected through the large-scale database 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 data 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 data 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.** (a) The commissioner shall convene a 17-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. One representative of the research community must be an individual with expertise in pharmacology or pharmaceutical economics who is familiar with the results of the pharmaceutical care research project at the University of Minnesota and the potential cost savings that can be achieved through use of a comprehensive pharmaceutical care model. 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, except that its existence does not terminate and members do not receive per diem compensation.

(b) The commissioner, upon the advice and recommendation of the practice parameter advisory committee, may convene expert review panels to assess practice parameters and outcome research associated with practice parameters.

History: *1992 c 549 art 7 s 3; 1993 c 247 art 5 s 7,8; 1993 c 345 art 3 s 18; art 12 s 5; 1994 c 625 art 8 s 25*

62J.33 INFORMATION ON COST AND QUALITY FOR PURCHASERS.

Subdivision 1. **Data analysis unit.** The data analysis unit shall provide information to assist group purchasers and consumers in making informed decisions regarding purchasing of health care services. The unit shall provide information allowing comparisons between integrated service networks and between health care services and systems. The unit shall collect information about:

(1) premiums, benefit levels, patient or enrollee satisfaction, managed care procedures, health care outcomes, and other features of integrated service networks, health plans, and health carriers;

(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; and

(3) information on health care services not provided through integrated service networks, including information on prices, costs, expenditures, utilization, quality of care, and outcomes.

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

Subd. 2. **Information clearinghouse.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, employers, providers, health carriers, and others to obtain information on health care costs and quality in Minnesota. The commissioner shall make available through the clearinghouse information developed or collected by the department of health on practice parameters, outcomes data and research, the costs and quality of integrated service networks, reports or recommendations of the health technology advisory committee and other entities on technology assessments, worksite wellness and prevention programs, other wellness programs, consumer education, and other initiatives. The clearinghouse shall, upon request, make available information submitted voluntarily by health plans, providers, employers, and others if the information clearly states that an entity other than the state submitted the information, identifies the entity, and states that distribution by the clearinghouse does not imply endorsement of the entity or the information by the commissioner of health or the state of Minnesota. The clearinghouse shall also refer requesters to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Subd. 3. **Office of consumer information.** The commissioner shall create an office of consumer information to assist health plan company enrollees and to serve as a resource center for enrollees. The office shall operate within the information clearinghouse. The functions of the office are:

(1) to assist enrollees in understanding their rights;

(2) to explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, integrated service networks, and the departments of health and commerce;

(3) to provide information on coverage options in each regional coordinating board region of the state;

(4) to provide information on the availability of purchasing pools and enrollee subsidies; and

(5) to help consumers use the health care system to obtain coverage.

The office of consumer information shall not provide legal services to consumers and shall not represent a consumer or enrollee. The office of consumer information shall not serve as an advocate for consumers in disputes with health plan companies. Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.031, subdivision 6, or other existing ombudsman programs.

Subd. 4. **Information on health plan companies.** The information clearinghouse shall provide information on all health plan companies operating in a specific geographic area to consumers and purchasers who request it.

Subd. 5. **Distribution of data on quality.** The commissioner shall make available through the clearinghouse hospital quality data collected under section 62J.45, subdivision 4b, and health plan company quality data collected under section 62J.45, subdivision 4c.

History: *1992 c 549 art 7 s 4; 1993 c 345 art 3 s 7,18; 1994 c 625 art 2 s 1-3*

62J.34 OUTCOME-BASED PRACTICE PARAMETERS.

Subdivision 1. **Practice parameters.** The data 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 data 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 data 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 the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, a board approved by the American Dental Association. The commissioner shall use rulemaking to approve practice parameters that are newly developed or substantially revised by the data analysis unit. Notice of adoption of practice parameters adopted without rulemaking must be published in the State Register and must include a statement that the complete practice parameter is available free of charge from the commissioner.

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, or product liability.

History: *1992 c 549 art 7 s 5; 1993 c 247 art 5 s 9,10; 1993 c 345 art 3 s 18; art 12 s 6*

62J.35 DATA COLLECTION.

Subdivision 1. **Data collection by commissioner.** For purposes of forecasting rates of growth in health care spending and setting limits under section 62J.04, subdivisions 1 and 1a, the commissioner may collect from health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. 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.

Subd. 2. **Failure to provide data.** The intentional failure to provide the data requested under this chapter is grounds for revocation of a license or other disciplinary or regulatory action against a regulated provider or group purchaser. The commissioner may assess a fine against a provider or group purchaser who refuses to provide data required by the commissioner. If a provider or group purchaser refuses to provide the data required, the commissioner may obtain a court order requiring the provider or group purchaser to produce documents and allowing the commissioner to inspect the records of the provider or group purchaser for purposes of obtaining the data required.

Subd. 3. **Data privacy.** All data received under this section or under section 62J.04, 62J.37, 62J.38, 62J.41, or 62J.42 is private or nonpublic, except to the extent that it is given a different classification elsewhere in this chapter. The commissioner shall establish procedures and safeguards to ensure that data released by the commissioner is in a form that does not identify specific patients, providers, employers, purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

Subd. 4. **Contracting.** The commissioner may contract with private organizations to carry out the data collection initiatives required by this chapter. The commissioner shall require in the contract that organizations under contract adhere to the data privacy requirements established under this chapter and chapter 13.

Subd. 5. **Rules.** The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs.

History: *1993 c 247 art 1 s 1; 1993 c 345 art 3 s 4,8,18; 1994 c 625 art 8 s 26,27*

62J.37 DATA FROM INTEGRATED SERVICE NETWORKS.

The commissioner shall require integrated service networks operating under section 62N.06, subdivision 1, to submit data on health care spending and revenue for calendar year 1994 by February 15, 1995. Each February 15 thereafter, integrated service networks shall submit to the commissioner data on health care spending and revenue for the preceding calendar year. The data must be provided in the form specified by the commissioner. To the extent that an integrated service network is operated by a group purchaser under section 62N.06, subdivision 2, the integrated service network is exempt from this section and the group purchaser must provide data on the integrated service network under section 62J.38.

History: *1993 c 345 art 3 s 9*

62J.38 DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by April 1, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, must be provided separately for the following categories: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency and out-of-area care, pharmacy services and prescription drugs, mental health services, chemical dependency services, other expenditures, subscriber liability, and administrative costs.

(c) State agencies and all other group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

History: *1993 c 345 art 3 s 10; 1994 c 625 art 8 s 28*

62J.40 DATA FROM STATE AGENCIES.

In addition to providing the data required under section 62J.38, the commissioners of human services, commerce, labor and industry, and employee relations and all other state departments or agencies that administer one or more health care programs shall provide to the commissioner of health any additional data on the health care programs they administer that is requested by the commissioner of health, including data in unaggregated form, for purposes of developing estimates of spending, setting spending limits, and monitoring actual spending. The data must be provided at the times and in the form specified by the commissioner of health.

History: *1993 c 345 art 3 s 11*

62J.41 DATA FROM PROVIDERS.

Subdivision 1. **Data to be collected from providers.** The commissioner shall require health care providers to collect and provide both patient specific information and descriptive and financial aggregate data on:

(1) the total number of patients served;

(2) the total number of patients served by state of residence and Minnesota county;

(3) the site or sites where the health care provider provides services;

(4) the number of individuals employed, by type of employee, by the health care provider;

(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

(9) revenue from out-of-pocket payments by patients;

(10) revenue from donations; and

(11) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs and quality.

Subd. 2. **Annual monitoring and estimates.** The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by April 1, 1994. Health care providers shall submit data for the 1994 calendar year by April 1, 1995, and each April 1 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioner of revenue shall provide any data collected to the commissioner of health.

Subd. 3. **Public health goals.** The commissioner shall establish specific public health goals including, but not limited to, increased delivery of prenatal care, improved birth outcomes, and expanded childhood immunizations. The commissioner shall consider the community public health goals and the input of the statewide advisory committee on community health in establishing the statewide goals. The commissioner shall require health care providers and integrated service networks to maintain and periodically report information on changes in health outcomes related to specific public health goals. The information must be provided at the times and in the form specified by the commissioner.

Subd. 4. **Regional public health goals.** The regional coordinating boards shall adopt regional public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota comprehensive adult mental health act and the Minnesota comprehensive children's mental health act, and community social service act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E.

History: *1993 c 345 art 3 s 12; 1994 c 625 art 8 s 29*

62J.42 QUALITY, UTILIZATION, AND OUTCOME DATA.

The commissioner shall also require group purchasers and health care providers to maintain and periodically report information on quality of care, utilization, and outcomes. The information must be provided at the times and in the form specified by the commissioner.

History: *1993 c 345 art 3 s 13*

62J.44 PUBLICATION OF DATA.

(a) Notwithstanding section 62J.35, subdivision 3, the commissioner may publish data on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, group purchasers, and integrated service networks, with a description of the methodology used for analysis, in order to provide information to purchasers and consumers of health care. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, group purchaser, or integrated service network until after the institution, group of professionals, individual health care professional, group purchaser, or integrated service network has had 15 days to review the data and comment. The commissioner shall include any comments received in the release of the data.

(b) Summary data derived from data collected under this chapter may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner or otherwise in accordance with chapter 13.

History: *1993 c 345 art 3 s 14*

62J.45 DATA INSTITUTE.

Subdivision 1. **Statement of purpose.** It is the intention of the legislature to create a public-private mechanism for the collection of health care costs, quality, and outcome data, to the extent administratively efficient and effective. This integrated data system will provide clear, usable information on the cost, quality, and structure of health care services in Minnesota.

The health reform initiatives being implemented rely heavily on the availability of valid, objective data that currently are collected in many forms within the health care industry. Data collection needs cannot be efficiently met by undertaking separate data collection efforts.

The data institute created in this section will be a partnership between the commissioner of health and a board of directors representing health carriers and other group purchasers, health care providers, and consumers. These entities will work together to establish a centralized cost and quality data system that will be used by the public and

private sectors. The data collection advisory committee and the practice parameter advisory committee shall provide assistance to the institute through the commissioner of health.

Subd. 2. **Definitions.** For purposes of this section, the following definitions apply.

(a) "Board" means the board of directors of the data institute.

(b) "Encounter level data" means data related to the utilization of health care services by, and the provision of health care services to individual patients, enrollees, or insureds, including claims data, abstracts of medical records, and data from patient interviews and patient surveys.

(c) "Health carrier" has the definition provided in section 62A.011, subdivision 2.

Subd. 3. **Objectives of the data institute.** The data institute shall:

(1) provide direction and coordination for public and private sector data collection efforts;

(2) establish a data system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost-effective, consumer-responsive health care system;

(3) use and build upon existing data sources and quality measurement efforts, and improve upon these existing data sources and measurement efforts through the integration of data systems and the standardization of concepts, to the greatest extent possible;

(4) ensure that each segment of the health care industry can obtain data for appropriate purposes in a useful format and timely fashion;

(5) protect the privacy of individuals and minimize administrative costs; and

(6) develop a public/private information system to:

(i) make health care claims processing and financial settlement transactions more efficient;

(ii) provide an efficient, unobtrusive method for meeting the shared data needs of the state, consumers, employers, providers, and group purchasers;

(iii) provide the state, consumers, employers, providers, and group purchasers with information on the cost, appropriateness and effectiveness of health care, and wellness and cost containment strategies;

(iv) provide employers with the capacity to analyze benefit plans and work place health; and

(v) provide researchers and providers with the capacity to analyze clinical effectiveness.

The institute shall carry out these activities in accordance with the recommendations of the data collection plan developed by the data collection advisory committee, the Minnesota health care commission, and the commissioner of health, under subdivision 4.

Subd. 4. **Data collection plan.** The commissioner, in consultation with the board of the institute and the data collection advisory committee, shall develop and implement a plan that:

(1) provides data collection objectives, strategies, priorities, cost estimates, administrative and operational guidelines, and implementation timelines for the data institute; and

(2) identifies the encounter level data needed for the commissioner to carry out the duties assigned in this chapter.

The plan must take into consideration existing data sources and data sources that can easily be made uniform for linkages to other data sets.

This plan shall be prepared by October 31, 1993.

Subd. 4a. **Evaluation of consumer satisfaction; provider information pilot study.** (a) The commissioner may make a grant to the data institute to develop and implement a mechanism for collecting comparative data on consumer satisfaction through adop-

tion of a standard consumer satisfaction survey. As a condition of receiving this grant, the data institute shall appoint a consumer advisory group which shall consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers, to advise the data institute on issues of concern to consumers. The advisory group must have at least one member from each regional coordinating board region of the state. The advisory group expires June 30, 1997. This survey shall include enrollees in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The data institute shall determine a mechanism for the inclusion of the uninsured. Health plan companies and group purchasers shall provide enrollment information, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this study to the data institute. This enrollment information provided by the health plan companies and group purchasers is classified as private data on individuals, as defined in section 13.02, subdivision 12. The data institute shall provide raw unaggregated data to the data analysis unit. The data institute may analyze and prepare findings from the raw, unaggregated data, and the findings from this survey may be included in the health plan company report cards, and in other reports developed by the data analysis unit, in consultation with the data institute, to be disseminated by the information clearinghouse. The raw unaggregated data is classified as private data on individuals as defined in section 13.02, subdivision 12. The survey may include information on the following subjects:

(1) enrollees' overall satisfaction with their health care plan;

(2) consumers' perception of access to emergency, urgent, routine, and preventive care, including locations, hours, waiting times, and access to care when needed;

(3) premiums and costs;

(4) technical competence of providers;

(5) communication, courtesy, respect, reassurance, and support;

(6) choice and continuity of providers;

(7) continuity of care;

(8) outcomes of care;

(9) services offered by the plan, including range of services, coverage for preventive and routine services, and coverage for illness and hospitalization;

(10) availability of information; and

(11) paperwork.

(b) The commissioner, in consultation with the data institute, shall develop a pilot study to collect comparative data from health care providers on opportunities and barriers to the provision of quality, cost-effective health care. The provider information pilot study shall include providers in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. Health plan companies and group purchasers shall provide to the commissioner providers' names, health plan assignment, and other appropriate data necessary for the commissioner to conduct the study. The provider information pilot study shall examine factors that increase and hinder access to the provision of quality, cost-effective health care. The study may examine:

(1) administrative barriers and facilitators;

(2) time spent obtaining permission for appropriate and necessary treatments;

(3) latitude to order appropriate and necessary tests, pharmaceuticals, and referrals to specialty providers;

(4) assistance available for decreasing administrative and other routine paperwork activities;

(5) continuing education opportunities provided;

(6) access to readily available information on diagnoses, diseases, outcomes, and new technologies;

(7) continuous quality improvement activities;

(8) inclusion in administrative decision-making;

(9) access to social services and other services that facilitate continuity of care;

(10) economic incentives and disincentives;

(11) peer review procedures; and

(12) the prerogative to address public health needs.

In selecting additional data for collection, the commissioner shall consider the: (1) statistical validity of the indicator; (2) public need for the information; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator to identify barriers and opportunities to improve quality care provision within health plan companies.

Subd. 4b. **Hospital quality indicators.** The commissioner, in consultation with the data institute, shall develop a system for collecting data on hospital quality. The commissioner shall require a licensed hospital to collect and report data as needed for the system. Data to be collected shall include structural characteristics including staff-mix and nurse-patient ratios. In selecting additional data for collection, the commissioner shall consider: (1) feasibility and statistical validity of the indicator; (2) purchaser and public demand for the indicator; (3) estimated expense of collecting and reporting the indicator; and (4) usefulness of the indicator for internal improvement purposes.

Subd. 4c. **Quality report cards.** (a) Each health plan company shall report annually by April 1 to the commissioner specific quality indicators, in the form specified by the commissioner in consultation with the data institute. The quality indicators must be reported using standard definitions and measurement processes as specified by the commissioner. Wherever possible, the commissioner's specifications must be consistent with any outlined in the health plan employer data and information set (HEDIS 2.0). The commissioner, in consultation with the data institute, may modify the quality indicators to be reported to incorporate improvements in quality measurement tools. When HEDIS 2.0 indicators or health care financing administration approved quality indicators for medical assistance and Medicare are used, the commissioner is exempt from rulemaking. For additions or modifications to the HEDIS indicators or if other quality indicators are added, the commissioner shall proceed through rulemaking pursuant to chapter 14. The data analysis unit shall develop quality report cards, and these report cards shall be disseminated through the information clearinghouse.

(b) Data shall be collected by county and high-risk and special needs populations as well as by health plan but shall not be reported. The commissioner, in consultation with the data institute and counties, shall provide this data to a community health board as defined in section 145A.02 in a manner that would not allow the identification of individuals.

Subd. 5. **Commissioner's duties.** (a) The commissioner shall establish a public/private data institute in conjunction with health care providers, health carriers and other group purchasers, and consumers, to collect and process encounter level data that are required to be submitted to the commissioner under this chapter. The commissioner shall not collect encounter level data from individual health care providers until standardized forms and procedures are available. The commissioner shall establish a board of directors comprised of members of the public and private sector to provide oversight for the administration and operation of the institute.

(b) Until the data institute is operational, the commissioner may collect encounter level data required to be submitted under this chapter.

(c) The commissioner, with the advice of the board, shall establish policies for the disclosure of data to consumers, purchasers, providers, integrated service networks, and plans for their use in analysis to meet the goals of this chapter, as well as for the public disclosure of data to other interested parties. The disclosure policies shall ensure that consumers, purchasers, providers, integrated service networks, and plans have

access to institute data for use in analysis to meet the goals of this chapter at the same time that data is provided to the data analysis unit in the department of health.

(d) The commissioner, with the advice of the board, may require those requesting data from the institute to contribute toward the cost of data collection through the payments of fees. Entities supplying data to the institute shall not be charged more than the actual transaction cost of providing the data requested.

(e) The commissioner may intervene in the direct operation of the institute, if this is necessary in the judgment of the commissioner to accomplish the institute's duties. If the commissioner intends to depart from the advice and recommendations of the board, the commissioner shall inform the board of the intended departure, provide the board with a written explanation of the reasons for the departure, and give the board the opportunity to comment on the departure.

Subd. 6. **Board of directors.** The institute is governed by a 20-member board of directors consisting of the following members:

(1) two representatives of hospitals, one appointed by the Minnesota Hospital Association and one appointed by the Metropolitan HealthCare Council, to reflect a mix of urban and rural institutions;

(2) four representatives of health carriers, two appointed by the Minnesota Council of Health Maintenance Organizations, one appointed by Blue Cross Blue Shield, and one appointed by the Insurance Federation of Minnesota;

(3) two consumer members, one appointed by the commissioner, and one appointed by the AFL-CIO as a labor union representative;

(4) five group purchaser representatives appointed by the Minnesota Consortium of Healthcare Purchasers to reflect a mix of urban and rural, large and small, and self-insured purchasers;

(5) two physicians appointed by the Minnesota Medical Association, to reflect a mix of urban and rural practitioners;

(6) one representative of teaching and research institutions, appointed jointly by the Mayo Foundation and the Minnesota Association of Public Teaching Hospitals;

(7) one nursing representative appointed by the Minnesota Nurses Association; and

(8) three representatives of state agencies, one member representing the department of employee relations, one member representing the department of human services, and one member representing the department of health.

Subd. 7. **Terms; compensation; removal; and vacancies.** The board is governed by section 15.0575.

Subd. 8. **Staff.** The board may hire an executive director. The executive director is not a state employee but is covered by section 3.736. The executive director may participate in the following plans for employees in the unclassified service: the state retirement plan, the state deferred compensation plan, and the health insurance and life insurance plans. The attorney general shall provide legal services to the board.

Subd. 9. **Duties.** The board shall provide assistance to the commissioner in developing and implementing a plan for the public/private information system. In addition, the board shall make recommendations to the commissioner on:

(1) the purpose of initiating data collection initiatives;

(2) the expected benefit to the state from the initiatives;

(3) the methodology needed to ensure the validity of the initiative without creating an undue burden to providers and payers;

(4) the most appropriate method of collecting the necessary data; and

(5) the projected cost to the state, health care providers, health carriers, and other group purchasers to complete the initiative.

Subd. 10. **Data collection.** The commissioner, in consultation with the data institute board, may select a vendor to:

(1) collect the encounter level data required to be submitted by group purchasers under sections 62J.38 and 62J.42, state agencies under section 62J.40, and health care providers under sections 62J.41 and 62J.42, using, to the greatest extent possible, standardized forms and procedures;

(2) collect the encounter level data required for the initiatives of the data analysis unit, under sections 62J.30 to 62J.34, using, to the greatest extent possible, standardized forms and procedures;

(3) process the data collected to ensure validity, consistency, accuracy, and completeness, and as appropriate, merge data collected from different sources;

(4) provide unaggregated, encounter level data to the data analysis unit within the department of health; and

(5) carry out other duties assigned in this section.

Subd. 11. **Use of data.** (a) The board of the data institute, with the advice of the data collection advisory committee and the practice parameter advisory committee through the commissioner, is responsible for establishing the methodology for the collection of the data and is responsible for providing direction on what data would be useful to the plans, providers, consumers, and purchasers.

(b) The data analysis unit is responsible for the analysis of the data and the development and dissemination of reports.

(c) The commissioner, in consultation with the board, shall determine when and under what conditions data disclosure to group purchasers, health care providers, consumers, researchers, and other appropriate parties may occur to meet the state's goals. The commissioner may require users of data to contribute toward the cost of data collection through the payment of fees. The commissioner shall require users of data to maintain the data according to the data privacy provisions applicable to the data.

(d) The commissioner and the board shall not allow a group purchaser or health care provider to use or have access to data collected by the data institute, unless the group purchaser or health care provider cooperates with the data collection efforts of the data institute by submitting all data requested in the form and manner specified by the board. The commissioner and the board shall prohibit group purchasers and health care providers from transferring, providing, or sharing data obtained from the data institute with a group purchaser or health care provider that does not cooperate with the data collection efforts of the data institute.

Subd. 12. **Contracting.** The commissioner, in consultation with the board, may contract with private sector entities to carry out the duties assigned in this section. The commissioner shall diligently seek to enter into contracts with private sector entities. Any contract must list the specific data to be collected and the methods to be used to collect and validate the data. Any contract must require the private sector entity to maintain the data collected according to the data privacy provisions applicable to the data.

Subd. 13. **Data privacy.** The board and the institute are subject to chapter 13.

Subd. 14. **Standards for data release.** The data institute shall adopt standards for the collection, by the institute, of data on costs, spending, quality, outcomes, and utilization. The data institute shall also adopt standards for the analysis and dissemination, by private sector entities, of data on costs, spending, quality, outcomes, and utilization provided to the private sector entities by the data institute. Both sets of standards must be consistent with data privacy requirements.

Subd. 15. **Information clearinghouse.** The commissioner shall coordinate the activities of the data institute with the activities of the information clearinghouse established in section 62J.33, subdivision 2.

Subd. 16. **Federal and other grants.** The commissioner, in collaboration with the board, shall seek federal funding and funding from private and other nonstate sources for the initiatives required by the board.

History: *1993 c 345 art 3 s 15,18; 1994 c 625 art 2 s 4-6; 1994 c 625 art 8 s 30*

62J.46 MONITORING AND REPORTS.

Subdivision 1. **Long-term care costs.** The commissioner, with the advice of the interagency long-term care planning committee established under section 144A.31, shall use existing state data resources to monitor trends in public and private spending on long-term care costs and spending in Minnesota. The commissioner shall recommend to the legislature any additional data collection activities needed to monitor these trends. State agencies collecting information on long-term care spending and costs shall coordinate with the interagency long-term care planning committee and the commissioner to facilitate the monitoring of long-term care expenditures in the state.

Subd. 2. **Cost shifting.** The commissioner shall monitor the extent to which reimbursement rates for government health care programs lead to the shifting of costs to private payers. By January 1, 1995, the commissioner shall report any evidence of cost shifting to the legislature and make recommendations on adjustments to the cost containment plan that should be made due to cost shifting.

History: *1993 c 345 art 3 s 16*

62J.47 MORATORIUM ON MERGERS OR ACQUISITIONS BY HEALTH CARRIERS.

Subdivision 1. **Definitions.** For purposes of this section, "health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 2. **Restrictions.** Until July 1, 1996, the following health carriers are prohibited from merging with, or acquiring, directly or indirectly, any other health carrier:

(1) a health carrier whose number of enrollees residing in the state in the previous calendar year exceeds five percent of the total number of insured persons in that year residing in the state of Minnesota; and

(2) a health carrier whose number of enrollees residing in the seven-county metropolitan area in the previous calendar year exceeds ten percent of the total number of insured persons in that year residing in the seven-county metropolitan area.

Subd. 3. **Enforcement.** The district court in Ramsey county has jurisdiction to enjoin an alleged violation of subdivision 2. The attorney general may bring an action to enjoin an alleged violation. The commissioner of health or commerce shall not issue or renew a license or certificate of authority to any health carrier in violation of subdivision 2.

Subd. 4. **Exceptions.** This section does not apply to:

(1) any merger or direct or indirect acquisition approved by the commissioner that is intended to assure continuous coverage for enrollees and avoid liquidation or insolvency under chapter 60B;

(2) any merger or direct or indirect acquisition that develops pursuant to a letter of intent, memorandum of understanding, or other agreement signed before March 17, 1994;

(3) any merger or direct or indirect acquisition that develops pursuant to an affiliation for which a letter of intent, memorandum of understanding, or other agreement was signed before March 17, 1994; or

(4) any merger or direct or indirect acquisition of health carriers that are related organizations, as defined in section 317A.011, subdivision 18, as of March 17, 1994.

History: *1994 c 625 art 8 s 31*

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144.802 are eligible for reimbursement under the integrated service network system and the regulated all-payer option. The commissioner shall require community integrated service networks, integrated service networks, and all-payer insurers to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician or nurse, and, if the person is an

enrollee in an integrated service network or community integrated service network, if approved by a designated representative of an integrated service network or a community service network who is immediately available on a 24-hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

History: *1994 c 625 art 4 s 1*

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 CITATION AND PURPOSE.

Subdivision 1. **Citation.** Sections 62J.50 to 62J.61 may be cited as the Minnesota health care administrative simplification act of 1994.

Subd. 2. **Purpose.** The legislature finds that significant savings throughout the health care industry can be accomplished by implementing a set of administrative standards and simplified procedures and by setting forward a plan toward the use of electronic methods of data interchange. The legislature finds that initial steps have been taken at the national level by the federal Health Care Financing Administration in its implementation of nationally accepted electronic transaction sets for its Medicare program. The legislature further recognizes the work done by the workgroup for electronic data interchange and the American National Standards Institute and its accredited standards committee X12, at the national level, and the Minnesota administrative uniformity committee, a statewide, voluntary, public-private group representing payers, hospitals, state programs, physicians, and other health care providers in their work toward administrative simplification in the health care industry.

History: *1994 c 625 art 9 s 1*

62J.51 DEFINITIONS.

Subdivision 1. **Scope.** For purposes of sections 62J.50 to 62J.61, the following definitions apply.

Subd. 2. **ANSI.** "ANSI" means the American National Standards Institute.

Subd. 3. **ASC X12** "ASC X12" means the American National Standards Institute committee X12.

Subd. 4. **Category I industry participants.** "Category I industry participants" means the following: group purchasers, providers, and other health care organizations doing business in Minnesota including public and private payers; hospitals; claims clearinghouses; third-party administrators; billing service bureaus; value added networks; self-insured plans and employers with more than 100 employees; clinic laboratories; durable medical equipment suppliers with a volume of at least 50,000 claims or encounters per year; and group practices with 20 or more physicians.

Subd. 5. **Category II industry participants.** "Category II industry participants" means all group purchasers and providers doing business in Minnesota not classified as category I industry participants.

Subd. 6. **Claim payment/advice transaction set (ANSI ASC X12 835).** "Claim payment/advice transaction set (ANSI ASC X12 835)" means the electronic transaction format developed and approved for implementation in October 1991, and used for electronic remittance advice and electronic funds transfer.

Subd. 7. **Claim submission transaction set (ANSI ASC X12 837).** "Claim submission transaction set (ANSI ASC X12 837)" means the electronic transaction format developed and approved for implementation in October 1992, and used to submit all health care claims information.

Subd. 8. **EDI.** "EDI" or "electronic data interchange" means the computer application to computer application exchange of information using nationally accepted standard formats.

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

Subd. 10. **Enrollment transaction set (ANSI ASC X12 834).** "Enrollment transaction set (ANSI ASC X12 834)" means the electronic transaction format developed and approved for implementation in February 1992, and used to transmit enrollment and benefit information from the employer to the payer for the purpose of enrolling in a benefit plan.

Subd. 11. **Group purchaser.** "Group purchaser" has the meaning given in section 62J.03, subdivision 6.

Subd. 12. **ISO.** "ISO" means the International Standardization Organization.

Subd. 13. **NCPDP.** "NCPDP" means the National Council for Prescription Drug Programs, Inc.

Subd. 14. **NCPDP telecommunication standard format 3.2.** "NCPDP telecommunication standard format 3.2" means the recommended transaction sets for claims transactions adopted by the membership of NCPDP in 1992.

Subd. 15. **NCPDP tape billing and payment format 2.0.** "NCPDP tape billing and payment format 2.0" means the recommended transaction standards for batch processing claims adopted by the membership of the NCPDP in 1993.

Subd. 16. **Provider.** "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

Subd. 17. **Uniform billing form HCFA 1450.** "Uniform billing form HCFA 1450" means the uniform billing form known as the HCFA 1450 or UB92, developed by the National Uniform Billing Committee in 1992 and approved for implementation in October 1993.

Subd. 18. **Uniform billing form HCFA 1500.** "Uniform billing form HCFA 1500" means the 1990 version of the health insurance claim form, HCFA 1500, developed by the uniform claims form task force of the federal Health Care Financing Administration.

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the 1990 uniform dental claim form developed by the American Dental Association.

Subd. 20. **Uniform pharmacy billing form.** "Uniform pharmacy billing form" means the National Council for Prescription Drug Programs/universal claim form (NCPDP/UCF).

Subd. 21. **WEDI.** "WEDI" means the National Workgroup for Electronic Data Interchange report issued in October 1993.

History: *1994 c 625 art 9 s 2*

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

Subdivision 1. **Uniform billing form HCFA 1450.** (a) On and after January 1, 1996, all institutional inpatient hospital services, ancillary services, and institutionally owned or operated outpatient services rendered by providers in Minnesota, that are not being billed using an equivalent electronic billing format, must be billed using the uniform billing form HCFA 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1450 shall be in accordance with the uniform billing form manual specified by the commissioner. In promulgating these instructions, the commissioner may utilize the manual developed by the National Uniform Billing Committee, as adopted and finalized by the Minnesota uniform billing committee.

(c) Services to be billed using the uniform billing form HCFA 1450 include: insti-

tutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); and institutional owned or operated outpatient services such as hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, including infusion therapy, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, community mental health centers, and any other health care provider certified by the Medicare program to use this form.

(d) On and after January 1, 1996, a mother and newborn child must be billed separately, and must not be combined on one claim form.

Subd. 2. **Uniform billing form HCFA 1500.** (a) On and after January 1, 1996, all noninstitutional health care services rendered by providers in Minnesota except dental or pharmacy providers, that are not currently being billed using an equivalent electronic billing format, must be billed using the health insurance claim form HCFA 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form HCFA 1500 shall be in accordance with the manual developed by the administrative uniformity committee entitled standards for the use of the HCFA 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form HCFA 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, podiatry services, optometry services, mental health licensed professional services, substance abuse licensed professional services, nursing practitioner professional services, certified registered nurse anesthetists, chiropractors, physician assistants, laboratories, medical suppliers, and other health care providers such as home health intravenous therapy providers, personal care attendants, day activity centers, waivered services, hospice, and other home health services, and freestanding ambulatory surgical centers.

Subd. 3. **Uniform dental billing form.** (a) On and after January 1, 1996, all dental services provided by dental care providers in Minnesota, that are not currently being billed using an equivalent electronic billing format, shall be billed using the American Dental Association uniform dental billing form.

(b) The instructions and definitions for the use of the uniform dental billing form shall be in accordance with the manual developed by the administrative uniformity committee dated February 1994, and as amended or further defined by the commissioner.

Subd. 4. **Uniform pharmacy billing form.** (a) On and after January 1, 1996, all pharmacy services provided by pharmacists in Minnesota that are not currently being billed using an equivalent electronic billing format shall be billed using the NCPDP/universal claim form, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform claim form shall be in accordance with instructions specified by the commissioner of health, except as provided in subdivision 5.

Subd. 5. **State and federal health care programs.** (a) Skilled nursing facilities and ICF-MR services billed to state and federal health care programs administered by the department of human services shall use the form designated by the department of human services.

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the HCFA 1450 for community men-

tal health center services and shall accept the HCFA 1500 for freestanding ambulatory surgical center services.

(c) State and federal health care programs administered by the department of human services shall be authorized to use the forms designated by the department of human services for pharmacy services and for child and teen checkup services.

(d) State and federal health care programs administered by the department of human services shall accept the form designated by the department of human services, and the HCFA 1500 for supplies, medical supplies, or durable medical equipment. Health care providers may choose which form to submit.

History: *1994 c 625 art 9 s 3*

62J.53 ACCEPTANCE OF UNIFORM BILLING FORMS BY GROUP PURCHASERS.

On and after January 1, 1996, all category I and II group purchasers in Minnesota shall accept the uniform billing forms prescribed under section 62J.52 as the only nonelectronic billing forms used for payment processing purposes.

History: *1994 c 625 art 9 s 4*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify health care provider organizations, except as provided in paragraph (d).

(b) Following the recommendation of the workgroup for electronic data interchange, the federal tax identification number assigned to each health care provider organization by the Internal Revenue Service of the Department of the Treasury shall be used as the unique identification number for health care provider organizations.

(c) The unique health care provider organization identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the Medicaid Management Information System or the uniform provider identification number (UPIN) assigned by the Health Care Financing Administration.

Subd. 2. **Unique identification number for individual health care providers.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify an individual health care provider, except as provided in paragraph (d).

(b) The uniform provider identification number (UPIN) assigned by the Health Care Financing Administration shall be used as the unique identification number for individual health care providers. Providers who do not currently have a UPIN number shall request one from the health care financing administration.

(c) The unique individual health care provider identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the Medicaid Management Information System or the uniform provider identification number (UPIN) assigned by the health care financing administration.

Subd. 3. **Unique identification number for group purchasers.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers.

(b) The federal tax identification number assigned to each group purchaser by the Internal Revenue Service of the Department of the Treasury shall be used as the unique identification number for group purchasers. This paragraph applies until the codes described in paragraph (c) are available and feasible to use, as determined by the commissioner.

(c) A two-part code, consisting of 11 characters and modeled after the National Association of Insurance Commissioners company code shall be assigned to each group purchaser and used as the unique identification number for group purchasers. The first six characters, or prefix, shall contain the numeric code, or company code, assigned by the National Association of Insurance Commissioners. The last five characters, or suffix, which is optional, shall contain further codes that will enable group purchasers to further route electronic transaction in their internal systems.

(d) The unique group purchaser identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

Subd. 4. **Unique patient identification number.** (a) On and after January 1, 1996, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (e).

(b) Except as provided in paragraph (d), following the recommendation of the workgroup for electronic data interchange, the social security number of the patient shall be used as the unique patient identification number.

(c) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The commissioner shall develop an alternate numbering system for patients who do not have or refuse to provide a social security number. This provision does not require that patients provide their social security numbers and does not require group purchasers or providers to demand that patients provide their social security numbers. Group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identification number.

(e) The state and federal health care programs administered by the department of human services shall use the unique person master index (PMI) identification number assigned to clients participating in programs administered by the department of human services.

History: *1994 c 625 art 9 s 5*

62J.55 PRIVACY OF UNIQUE IDENTIFIERS.

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.30, subdivision 6. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92-1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unencrypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section 144.335. The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

History: *1994 c 625 art 9 s 6*

62J.56 IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.

Subdivision 1. **General provisions.** (a) The legislature finds that there is a need to advance the use of electronic methods of data interchange among all health care participants in the state in order to achieve significant administrative cost savings. The legislature also finds that in order to advance the use of health care electronic data interchange in a cost-effective manner, the state needs to implement electronic data interchange standards that are nationally accepted, widely recognized, and available for immediate use. The legislature intends to set forth a plan for a systematic phase in of uniform health care electronic data interchange standards in all segments of the health care industry.

(b) The commissioner of health, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, shall administer the implementation of and monitor compliance with, electronic data interchange standards of health care participants, according to the plan provided in this section.

(c) The commissioner may grant exemptions to category I and II industry participants from the requirements to implement some or all of the provisions in this section if the commissioner determines that the cost of compliance would place the organization in financial distress, or if the commissioner determines that appropriate technology is not available to the organization.

Subd. 2. **Identification of core transaction sets.** (a) All category I and II industry participants in Minnesota shall comply with the standards developed by the ANSI ASC X12 for the following core transaction sets, according to the implementation plan outlined for each transaction set.

(1) ANSI ASC X12 835 health care claim payment/advice transaction set.

(2) ANSI ASC X12 837 health care claim transaction set.

(3) ANSI ASC X12 834 health care enrollment transaction set.

(4) ANSI ASC X12 270/271 health care eligibility transaction set.

(b) The commissioner, with the advice of the Minnesota health data institute and the Minnesota administrative uniformity committee, and in coordination with federal efforts, may approve the use of new ASC X12 standards, or new versions of existing standards, as they become available, or other nationally recognized standards, where appropriate ASC X12 standards are not available for use. These alternative standards may be used during a transition period while ASC X12 standards are developed.

Subd. 3. **Implementation guides.** (a) The commissioner, with the advice of the Minnesota administrative uniformity committee, and the Minnesota center for health care electronic data interchange shall review and recommend the use of guides to implement the core transaction sets. Implementation guides must contain the background and technical information required to allow health care participants to implement the transaction set in the most cost-effective way.

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the national Uniform Billing Committee and its state representative organization; the American Medical Association through the uniform claim task force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

History: *1994 c 625 art 9 s 7*

62J.57 MINNESOTA CENTER FOR HEALTH CARE ELECTRONIC DATA INTERCHANGE.

(a) It is the intention of the legislature to support, to the extent of funds appropri-

ated for that purpose, the creation of the Minnesota center for health care electronic data interchange as a broad-based effort of public and private organizations representing group purchasers, health care providers, and government programs to advance the use of health care electronic data interchange in the state. The center shall attempt to obtain private sector funding to supplement legislative appropriations, and shall become self-supporting by the end of the second year.

(b) The Minnesota center for health care electronic data interchange shall facilitate the statewide implementation of electronic data interchange standards in the health care industry by:

(1) coordinating and ensuring the availability of quality electronic data interchange education and training in the state;

(2) developing an extensive, cohesive health care electronic data interchange education curriculum;

(3) developing a communications and marketing plan to publicize electronic data interchange education activities, and the products and services available to support the implementation of electronic data interchange in the state;

(4) administering a resource center that will serve as a clearinghouse for information relative to electronic data interchange, including the development and maintenance of a health care constituents database, health care directory and resource library, and a health care communications network through the use of electronic bulletin board services and other network communications applications; and

(5) providing technical assistance in the development of implementation guides, and in other issues including legislative, legal, and confidentiality requirements.

History: *1994 c 625 art 9 s 8*

62J.58 IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. **Claims payment.** (a) By July 1, 1995, all category I industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic transfer of payment information.

(b) By July 1, 1996, all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version 3030) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Beginning July 1, 1995, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version 3030) for the electronic transfer of health care claim information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning July 1, 1996.

Subd. 3. **Enrollment information.** Beginning January 1, 1996, all category I industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version 3030) for the electronic transfer of enrollment and health benefit information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 4. **Eligibility information.** By January 1, 1996, all category I industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version 3030) for the electronic transfer of health benefit eligibility information. Category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, this transaction set, beginning January 1, 1997.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to

do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

History: *1994 c 625 art 9 s 9*

62J.59 IMPLEMENTATION OF NCPDP TELECOMMUNICATIONS STANDARD FOR PHARMACY CLAIMS.

(a) Beginning January 1, 1996, all category I and II pharmacists licensed in this state shall accept the NCPDP telecommunication standard format 3.2 or the NCPDP tape billing and payment format 2.0 for the electronic submission of claims as appropriate.

(b) Beginning January 1, 1996, all category I and category II group purchasers in this state shall use the NCPDP telecommunication standard format 3.2 or NCPDP tape billing and payment format 2.0 for electronic submission of payment information to pharmacists.

History: *1994 c 625 art 9 s 10*

62J.60 STANDARDS FOR THE MINNESOTA UNIFORM HEALTH CARE IDENTIFICATION CARD.

Subdivision 1. **Minnesota health care identification card.** All individuals with health care coverage shall be issued health care identification cards by group purchasers as of January 1, 1998. The health care identification cards shall comply with the standards prescribed in this section.

Subd. 2. **General characteristics.** (a) The Minnesota health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional.

(b) The Minnesota health care identification card must have an essential information window in the front side with the following data elements left justified in the following top to bottom sequence: issuer name, issuer number, identification number, identification name. No optional data may be interspersed between these data elements. The window must be left justified.

(c) Standardized labels are required next to human readable data elements. The card issuer may decide the location of the standardized label relative to the data element.

Subd. 3. **Human readable data elements.** (a) The following are the minimum human readable data elements that must be present on the front side of the Minnesota health care identification card:

(1) issuer name or logo, which is the name or logo that identifies the card issuer. The issuer name or logo may be the card's front background. No standard label is required for this data element;

(2) issuer number, which is the unique card issuer number consisting of a base number assigned by a registry process followed by a suffix number assigned by the card issuer. The use of this element is mandatory within one year of the establishment of a process for this identifier. The standardized label for this element is "Issuer";

(3) identification number, which is the unique identification number of the individual card holder established and defined under this section. The standardized label for the data element is "ID";

(4) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

(5) account number(s), which is any other number, such as a group number, if required for part of the identification or claims process. The standardized label for this data element is "Account";

(6) care type, which is the description of the group purchaser's plan product under which the beneficiary is covered. The description shall include the health plan company name and the plan or product name. The standardized label for this data element is "Care Type";

(7) service type, which is the description of coverage provided such as hospital, dental, vision, prescription, or mental health. The standard label for this data element is "Svc Type"; and

(8) provider/clinic name, which is the name of the primary care clinic the cardholder is assigned to by the health plan company. The standard label for this field is "PCP." This information is mandatory only if the health plan company assigns a specific primary care provider to the cardholder.

(b) The following human readable data elements shall be present on the back side of the Minnesota health identification card. These elements must be left justified, and no optional data elements may be interspersed between them:

(1) claims submission name(s) and address(es), which are the name(s) and address(es) of the entity or entities to which claims should be submitted. If different destinations are required for different types of claims, this must be labeled;

(2) telephone number(s) and name(s); which are the telephone number(s) and name(s) of the following contact(s) with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the card for health maintenance organizations and integrated service networks:

(1) emergency care authorization telephone number or instruction on how to receive authorization for emergency care. There is no standard label required for this information; and

(2) telephone number to call to appeal to the commissioner of health. There is no standard label required for this information.

(d) All human readable data elements not required under paragraphs (a) to (c) are optional and may be used at the issuer's discretion.

Subd. 4. **Machine readable data content.** The Minnesota health care identification card may be machine readable or nonmachine readable. If the card is machine readable, the card must contain a magnetic stripe that conforms to ANSI and ISO standards for Tracks 1.

History: *1994 c 625 art 9 s 11*

62J.61 RULEMAKING; IMPLEMENTATION.

The commissioner of health is exempt from rulemaking in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59. The commissioner shall publish proposed rules in the State Register. Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish the final rules in the State Register 30 days before they are to take effect. The commissioner may use emergency and permanent rulemaking to implement the remainder of this article. The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter. The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

History: *1994 c 625 art 9 s 12*

62J.65 EXEMPTION.

Patient revenues derived from non-Minnesota patients are exempt from the regulated all-payer system and Medicare balance billing prohibition under section 62J.25.

History: *1994 c 625 art 8 s 32*