CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system. 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 restructured health care financing and delivery system must be enacted or adopted by January 1, 1996.

History: *1995 c 234 art 3 s 1*

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

[For text of subd 1, see M.S.1994]

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 the implementation of the growth limits. This annual report shall describe the 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, in consultation with the Minnesota health care commission, shall research and include in the annual report required in paragraph (a) for 1996, recommendations regarding the implementation of growth limits for health plan companies and providers. The commissioner shall:

(1) consider both spending and revenue approaches and report on the implementation of the interim limits as defined in sections 62J.041 and 62J.042;

(2) make recommendations regarding the enforcement mechanism and consider mechanisms to adjust future growth limits as well as mechanisms to establish financial penalties for noncompliance;

(3) address the feasibility of systemwide limits imposed on all integrated service networks; and

(4) make recommendations on the most effective way to implement growth limits on the fee–for–service system in the absence of a regulated all–payer system.

(c) The commissioner shall enforce limits on growth in spending for health plan companies and revenues for providers. 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.

(d) The commissioner shall impose and enforce overall limits on growth in spending for health plan companies, with adjustments for changes in enrollment, benefits, severity, and risks. If a health plan company exceeds the growth limits, the commissioner may impose financial penalties up to the amount exceeding the applicable growth limit.

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

(8) 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; and

(9) 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.

[For text of subds 4 to 9, see M.S.1994]

History: *1995 c 234 art 3 s 2; art 5 s 2*

62J.041 INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS.

Subdivision 1. **Definitions.** (a) For purposes of this section, the following definitions apply.

(b) "Health plan company" has the definition provided in section 62Q.01.

(c) "Total expenditures" means incurred claims or expenditures on health care services, administrative expenses, charitable contributions, and all other payments made by health plan companies out of premium revenues.

(d) "Net expenditures" means total expenditures minus exempted taxes and assessments and payments or allocations made to establish or maintain reserves.

(e) "Exempted taxes and assessments" means direct payments for taxes to government agencies, contributions to the Minnesota comprehensive health association, the medical assistance provider's surcharge under section 256.9657, the MinnesotaCare provider tax under section 295.52, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, assessments by the Minnesota risk adjustment association, and any new assessments imposed by federal or state law.

(f) "Consumer cost–sharing or subscriber liability" means enrollee coinsurance, copayment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in net expenditures by each health carrier plan company for calendar years 1994, 1995, 1996, and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may elect to meet one combined expenditure limit.

Subd. 3. **Determination of expenditures.** Health plan companies shall submit to the commissioner of health, by April 1, 1994, for calendar year 1993; April 1, 1995, for calendar year 1994; April 1, 1996, for calendar year 1995; April 1, 1997, for calendar year 1996; and April 1, 1998, for calendar year 1997 all information the commissioner determines to be necessary to implement and enforce this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments and the election to meet one expenditure limit for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates.

(b) Health plan companies shall fully reflect in the premium rates the savings generated by the expenditure limits. No premium rate, currently reviewed by the departments of health or commerce, may be approved for those health plan companies unless the health plan company establishes to the satisfaction of the commissioner of commerce or the commissioner of health, as appropriate, that the proposed new rate would comply with this paragraph.

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year.

These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as an integrated service network or community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of corrective action to the commissioner of health or commerce under subdivision 7.

(e) The commissioner of commerce, in consultation with the commissioner of health, shall report to the legislature no later than January 15, 1995, as to whether the concept of a reserve corridor or other mechanism for purposes of monitoring reserves is adaptable for use with indemnity health insurers that do business in multiple states and that must comply with their domiciliary state's reserves requirements.

Subd. 5. **Notice.** The commissioner of health shall publish in the State Register and make available to the public by July 1, 1995, a list of all health plan companies that exceeded their expenditure limit for the 1994 calendar year. The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined expenditure limit for calendar years 1994 and 1995. The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its expenditure limit, at least 30 days before publishing the list, and shall provide each health plan company with ten days to provide an explanation for exceeding the expenditure limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

Subd. 6. **Assistance by the commissioner of commerce.** The commissioner of commerce shall provide assistance to the commissioner of health in monitoring health plan companies regulated by the commissioner of commerce. The commissioner of commerce, in consultation with the commissioner of health, shall enforce compliance with expenditure limits for those health plan companies.

Subd. 7. **Enforcement.** (a) The commissioners of health and commerce shall enforce the reserve limits referenced in subdivision 4, with respect to the health plan companies that each commissioner respectively regulates. Each commissioner shall require health plan companies under the commissioner's jurisdiction to submit plans of corrective action when the reserve requirement is not met. The plan of correction must address the following:

(1) actuarial assumptions used in forecasting future financial results;

(2) trend assumptions used in setting future premiums;

(3) demographic, geographic, and private and public sector mix of the population covered by the health plan company;

(4) proposed rate increases or decreases;

(5) growth limits applied under section 62J.04, subdivision 1, paragraph (b); and

(6) other factors deemed appropriate by the health plan company or commissioner.

If the health plan company's reserves exceed the required maximum, the plan of correction shall address how the health plan company will come into compliance and set forth a timetable within which compliance would be achieved. The plan of correction may propose premium refunds, credits for prior premiums paid, policyholder dividends, or any combination of these or other methods which will benefit enrollees and/or Minnesota residents and are such that the reserve requirements can reasonably be expected to be met. The commissioner's evaluation of the plan of correction must consider:

(1) whether implementation of the plan would provide the company with an unfair advantage in the market;

(2) the extent to which the reserve excess was created by any movement of enrolled persons to another organization formed by the company;

(3) whether any proposed premium refund, credit, and/or dividend represents an equitable allocation to policyholders covered in prior periods as determined using sound actuarial practice; and

(4) any other factors deemed appropriate by the applicable commissioner.

(b) The plan of correction is subject to approval by the commissioner of health or commerce, as applicable. If such a plan is not approved by the applicable commissioner, the applicable commissioner shall enter an order stating the steps that the health plan company must take to come into compliance. Within 30 days of the date of such order, the health plan company must file a notice of appeal with the applicable commissioner or comply with the commissioner's order. If an appeal is filed, such appeal is governed by chapter 14.

(c) Health plan companies that exceed the expenditure limits based on two–year average expenditure data (1994 and 1995, 1996 and 1997) shall be required by the appropriate commissioner to pay back the amount exceeding the expenditure limit through an assessment on the health plan company. A health plan company may appeal the commissioner's order to pay back the amount exceeding the expenditure limit by mailing to the commissioner a written notice of appeal within 30 days from the date the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The health plan company shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund. The appropriate commissioner may approve a different repayment method to take into account the health plan company's financial condition. Health plan companies shall comply with the limits but shall also guarantee that their contractual obligations are met. Health plan companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles and amounts in excess of benefit plan maximums.

History: *1993 c 345 art 2 s 4; 1994 c 625 art 3 s 4; 1995 c 234 art 3 s 9*

62J.042 HEALTH CARE PROVIDER REVENUE LIMITS.

Subdivision 1. **Definition.** For purposes of this section, "health care provider" has the definition given in section 62J.03, subdivision 8.

Subd. 2. **Establishment.** The commissioner of health shall establish limits on the increase in revenue for each health care provider, for calendar years 1994, 1995, 1996, and 1997. The limits must be the same as the annual rate of growth in health care spending established under section 62J.04, subdivision 1, paragraph (b). The commissioner may adjust final revenue figures for case mix complexity, payer mix, out–of–period settlements, certain taxes and assessments including the MinnesotaCare provider tax and provider surcharge, any new assessments imposed by federal or state law, research and education costs, donations, grants, and legislative initiatives that materially change health care revenues, as long as these adjustments are consistent with the methodology submitted by the health care provider to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by September 1, 1994. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 3. **Monitoring of revenue.** The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor

hospital revenue by examining net inpatient revenue per adjusted admission and net outpatient revenue per outpatient visit. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. For purposes of this section, definitions related to the implementation of limits for providers other than hospitals are included in Minnesota Rules, chapter 4650, and definitions related to the implementation of limits for hospitals are included in Minnesota Rules, chapter 4651. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees.

Subd. 4. **Monitoring and enforcement.** Health care providers shall submit to the commissioner of health, in the form and at the times required by the commissioner, all information the commissioner determines to be necessary to implement and enforce this section. The commissioner shall regularly audit all health clinics employing or contracting with over 100 physicians. The commissioner shall also audit, at times and in a manner that does not interfere with delivery of patient care, a sample of smaller clinics and other health care providers. Providers that exceed revenue limits based on two–year average revenue data shall be required by the commissioner to pay back the amount exceeding the revenue limits during the following calendar year.

Pharmacists may adjust their revenue figures for increases in drug product costs that are set by the manufacturer. The commissioner shall consult with pharmacy groups, including pharmacies, wholesalers, drug manufacturers, health plans, and other interested parties, to determine the methodology for measuring and implementing the interim growth limits while taking into account the adjustments for drug product costs.

The commissioner shall monitor providers meeting the growth limits based on their current fees on an annual basis. The fee charged for each service must be based on a weighted average across 12 months and compared to the weighted average for the previous 12–month period. The percentage increase in the average fee from 1993 to 1994, and from 1994 to 1995 is subject to the growth limits established under section 62J.04, subdivision 1, paragraph (b). The percentage increase in the average fee from 1995 to 1996, and from 1996 to 1997 is subject to the change in the regional consumer price index for urban consumers for the previous year published in the State Register in January of the year that the growth limit is in effect. The audit process may include a review of the provider's monthly fee schedule, and a random claims analysis for the provider during different parts of the year to monitor variations in fees. The commissioner shall require providers that exceed growth limits, based on annual fees, to pay back during the following calendar year the amount of fees received exceeding the limit.

The commissioner shall notify each provider that has exceeded its revenue or fee limit, at least 30 days before taking action, and shall provide each provider with ten days to provide an explanation for exceeding the revenue or fee limit. The commissioner shall review the explanation and may change a determination if the commissioner determines the explanation to be valid.

The commissioner may approve a different repayment schedule for a health care provider that takes into account the provider's financial condition.

A provider may appeal the commissioner's order to pay back the amount exceeding the revenue or fee limit by mailing a written notice of appeal to the commissioner within 30 days after the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The provider shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 3.762 to 3.765, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund.

Subd. 5. **Small rural hospitals.** Each small rural hospital shall file information with the commissioner of health and calculate its growth in revenues pursuant to the requirements of this chapter. Small rural hospitals that do not file as part of a hospital system are exempt from the repayment provisions of subdivision 4. However, the commissioner retains the authority to initiate an investigation and order repayment pursuant to this section, if the commissioner believes that there is an unreasonable rate of growth in revenues and if the hospital fails to

demonstrate good cause for exceeding the statutory growth limits. For purposes of this subdivision, small rural hospital is defined as a hospital with less than 50 licensed beds.

History: *1993 c 345 art 2 s 5; 1Sp1993 c 6 s 38; 1994 c 625 art 3 s 5; 1995 c 234 art 3 s 9; art 8 s 15,16*

62J.045 [Repealed, 1995 c 234 art 8 s 57]

62J.05 MINNESOTA HEALTH CARE COMMISSION.

[For text of subd 1, see M.S.1994]

Subd. 2. **Membership.** (a) **Number.** The Minnesota health care commission consists of 28 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) **Regional coordinating boards.** The commission includes one member who is the chair of a regional coordinating board, elected by a majority vote of the chairs of the regional coordinating boards.

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

[For text of subds 3 to 8, see M.S.1994]

Subd. 9. **Repealer.** This section is repealed effective July 1, 2000.

History: *1995 c 234 art 8 s 1,2*

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, or the health technology ad-

visory committee established under section 62J.15, 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: *1995 c 234 art 5 s 3*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

[For text of subds 1 to 3, see M.S.1994]

Subd. 4. [Repealed, 1995 c 234 art 8 s 57]

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 coordinating boards may:

(1) undertake voluntary activities to educate consumers, providers, and purchasers about community plans and projects promoting health care cost containment, consumer accountability, access, and quality and efforts to achieve public health goals;

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

(3) 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;

(4) advise the commissioner on 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, the Minnesota comprehensive children's mental health act, and the community social service act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E;

(5) prepare an annual regional education plan that is consistent with and supportive of public health goals identified by community health boards in the region; and

(6) serve as advisory bodies to identify potential applicants for federal Health Professional Shortage Area and federal Medically Underserved Area designation as requested by the commissioner.

Subd. 1a. [Repealed, 1995 c 234 art 8 s 57]

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 member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) **Employer representatives.** Regional boards include three members representing employers in the region. Employer representatives are 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 legislative commission on health care access. 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. 3a. **Communication with health care commission.** The chairs of the regional coordinating boards shall meet with the chair and the executive director of the health care commission on a periodic basis, but no less than biennially.

[For text of subds 4 and 5, see M.S.1994]

Subd. 6. **Technical assistance.** The commissioner shall provide technical assistance to regional coordinating boards. Technical assistance includes providing each regional board with timely information concerning action plans, enrollment data, and health care expenditures affecting the regional board's region.

[For text of subds 6a and 7, see M.S.1994]

Subd. 8. **Repealer.** This section is repealed effective July 1, 2000.

History: *1995 c 234 art 3 s 3; art 8 s 3–7*

NOTE: Subdivision 1a was also amended by Laws 1995, chapter 234, article 3, section 3, to read as follows:

"Subd. 1a. **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."

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

[For text of subds 1 to 4, see M.S.1994]

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 organizations in the development of practice parameters;

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

(5) by consumers in making decisions about treatment;

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

(7) 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.

Subd. 6. [Repealed, 1995 c 234 art 3 s 10]

[For text of subd 7, see M.S.1994]

History: *1995 c 234 art 3 s 4*

62J.17 EXPENDITURE REPORTING.

[For text of subds 1 to 3, see M.S.1994]

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, including the specific dollar amount of each expenditure, 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.

[For text of subd 5a, see M.S.1994]

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 subdivision 7. 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 subdivision 7. 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) **Penalties and remedies.** The commissioner of health has the authority to issue fines, seek injunctions, and pursue other remedies as provided by law.

Subd. 7. **Exceptions.** (a) The retrospective review process as described in subdivision 5a and the prospective review and approval process as described in subdivision 6a do not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment used for direct patient care, upgrades of equipment beyond the current model, or comparable model must be reported;

(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;

(4) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance–related expenditures;

(5) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service–related activities; and

(6) a major spending commitment for computer equipment or data systems not directly related to the delivery of patient care services, including computer equipment or data systems related to medical record automation.

(b) In addition to the exceptions listed in paragraph (a), the prospective review and approval process described in subdivision 6a does not apply to 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.

History: *1995 c 234 art 8 s 8–10*

62J.19 [Repealed, 1995 c 234 art 8 s 57]

62J.212 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.

History: *1995 c 234 art 5 s 4*

INFORMATION CLEARINGHOUSE

62J.2930 INFORMATION CLEARINGHOUSE.

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, em-

ployers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the department of health on cost containment or other research initiatives, the development of integrated service networks, and voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of the health technology advisory committee and other entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Subd. 2. **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. 3. **Consumer information.** The information clearinghouse or another entity designated by the commissioner shall provide consumer information to health plan company enrollees to:

(1) assist enrollees in understanding their rights;

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

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

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

The information clearinghouse or other entity designated by the commissioner for the purposes of this subdivision shall not:

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) 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. **Coordination.** To the extent possible, the commissioner shall coordinate the activities of the clearinghouse with the activities of the Minnesota health data institute.

History: *1995 c 234 art 5 s 5*

62J.30 [Repealed, 1995 c 234 art 5 s 24]

62J.301 RESEARCH AND DATA INITIATIVES.

Subdivision 1. **Definitions.** For purposes of sections 62J.2930 to 62J.42, the following definitions apply:

(a) "Health outcomes data" means data used in 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.

(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.

Subd. 2. **Statement of purpose.** The commissioner of health shall conduct data and research initiatives in order to monitor and improve the efficiency and effectiveness of health care in Minnesota.

Subd. 3. **General duties.** The commissioner shall:

(1) collect and maintain data which enable population–based monitoring and trending of the access, utilization, quality, and cost of health care services within Minnesota;

(2) collect and maintain data for the purpose of estimating total Minnesota health care expenditures and trends;

(3) collect and maintain data for the purposes of setting limits under section 62J.04, and measuring growth limit compliance;

(4) conduct applied research using existing and new data and promote applications based on existing research;

(5) develop and implement data collection procedures to ensure a high level of cooperation from health care providers and health plan companies, as defined in section 62Q.01, subdivision 4;

(6) work closely with health plan companies and health care providers to promote improvements in health care efficiency and effectiveness; and

(7) 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.

Subd. 4. **Information to be collected.** (a) The data collected may include health outcomes data, patient functional status, and health status. The data collected may 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.321, subdivision 1.

(b) The commissioner may:

(1) collect the encounter level data required for the research and data initiatives of sections 62J.301 to 62J.42, using, to the greatest extent possible, standardized forms and procedures; and

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

(c) For purposes of estimating total health care spending and forecasting rates of growth in health care spending, the commissioner may collect from health care providers data on patient revenues and health care spending 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 and group purchasers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 5. **Nonlimiting.** Nothing in this chapter shall be construed to limit the powers granted to the commissioner of health under chapter 62D, 62N, 144, or 144A.

History: *1995 c 234 art 5 s 6*

62J.31 [Repealed, 1995 c 234 art 5 s 24]

62J.311 ANALYSIS AND USE OF DATA.

Subdivision 1. **Data analysis.** The commissioner shall analyze the data collected to:

(1) assist the state in developing and refining its health policy in the areas of access, utilization, quality, and cost;

(2) assist the state in promoting efficiency and effectiveness in the financing and delivery of health services;

(3) monitor and track accessibility, utilization, quality, and cost of health care services within the state;

(4) evaluate the impact of health care reform activities;

(5) assist the state in its public health activities; and

(6) evaluate and determine the most appropriate methods for ongoing data collection.

Subd. 2. **Criteria for data and research initiatives.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, 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 people with low-income, and health plan companies as applicable;

(2) be based on scientifically sound and statistically valid methods;

(3) 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 broad and representative health care data for research comparisons and applications;

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

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

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

(b) 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 data that allows the evaluation of state health care financing and delivery programs.

History: *1995 c 234 art 5 s 7*

62J.32 [Repealed, 1995 c 234 art 5 s 24]

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

Subdivision 1. **Data collection.** (a) The commissioner shall collect data from health care providers, health plan companies, and individuals in the most cost-effective manner, which does not unduly burden them. The commissioner may require health care providers and health plan companies to collect and provide patient health records and claim files, and cooperate in other ways with the data collection process. The commissioner may also require health care providers and health plan companies to provide mailing lists of patients. Patient consent shall not be required for the release of data to the commissioner pursuant to sections 62J.301 to 62J.42 by any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider. Any group purchaser, health plan company, health care provider; or agent, contractor, or association acting on behalf of a group purchaser or health care provider, that releases data to the commissioner in good faith pursuant to sections 62J.301 to 62J.42 shall be immune from civil liability and criminal prosecution.

(b) When a group purchaser, health plan company, or health care provider submits patient identifying data, as defined in section 62J.451, to the commissioner pursuant to sections 62J.301 to 62J.42, and the data is submitted to the commissioner in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system defined in section 62J.451, the group purchaser, health plan company, or health care provider shall submit the patient identifying data in encrypted form, using an encryption method specified by the commissioner. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.335, subdivision 3b.

(c) 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 plan companies when reporting data under this chapter. The commissioner must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consis-

tent with chapter 13 and sections 62J.55 and 144.335. This encryption must ensure that any data released must be in a form that makes it impossible to identify individual patients.

Subd. 2. **Failure to provide data.** The intentional failure to provide the data requested under this chapter is grounds for 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 collection and review.** Data collection 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; monitoring for changes in practice patterns; and the data and research criteria of section 62J.311, subdivision 2, to be fulfilled.

Subd. 4. **Use of existing data.** (a) The commissioner shall negotiate with private sector organizations currently collecting health care data of interest to the commissioner to obtain required data in a cost–effective manner and minimize administrative costs. The commissioner shall attempt to establish links between the health care data collected to fulfill sections 62J.301 to 62J.42 and existing private sector data and shall consider and implement methods to streamline data collection in order to reduce public and private sector administrative costs.

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

Subd. 5. **Data classification.** (a) Data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. 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, individual or group purchasers, or other specific individuals and organizations, except with the permission of the affected individual or organization, or as permitted elsewhere in this chapter.

(b) Raw unaggregated data collected from household and employer surveys used by the commissioner to monitor the number of uninsured individuals, reasons for lack of insurance coverage, and to evaluate the effectiveness of health care reform, are subject to the same data classifications as data collected pursuant to sections 62J.301 to 62J.42.

(c) Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the commissioner pursuant to sections 62J.301 to 62J.42, shall retain the classification designated under this section and shall not be disclosed other than pursuant to this section.

(d) Summary data collected to fulfill the data and research initiatives authorized by sections 62J.301 to 62J.42 may be disseminated under section 13.05, subdivision 7. For the purposes of this section, summary data includes nonpublic data not on individuals.

(e) Notwithstanding paragraph (a), the commissioner may publish nonpublic or private data collected pursuant to sections 62J.301 to 62J.42 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. The commissioner may not make public any patient identifying information except as specified in law. 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 21 days to review the data and comment. The commissioner shall include comments received in the release of the data.

(f) A provider or group purchaser may contest whether the data meets the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2), in accordance with a contested case proceeding as set forth in sections 14.57 to 14.62, subject to appeal in accordance with sections 14.63 to 14.68. To obtain a contested case hearing, the provider or group purchaser must make a written request to the commissioner before the end of the time period for review and comment. Within ten days of the assignment of an administrative law judge, the provider or group purchaser shall make a clear showing to the administrative law judge of probable success in a hearing on the issue of whether the data are accurate and valid and were collected based on the criteria of section 62J.311, subdivision 2, paragraph (a), clause (2). If the administrative law judge determines that the provider or group purchaser has made such a showing, the data shall remain private or nonpublic during the contested case proceeding and appeal. If the administrative law judge determines that the provider or group purchaser has not made such a showing, the commissioner may publish the data immediately, with comments received in the release of the data. The contested case proceeding and subsequent appeal is not an exclusive remedy and any person may seek a remedy pursuant to section 13.08, subdivisions 1 to 4, or as otherwise authorized by law.

Subd. 6. **Rulemaking.** The commissioner may adopt rules to implement sections 62J.301 to 62J.452.

Subd. 7. **Federal and other grants.** The commissioner may seek federal funding, and funding from private and other nonstate sources, for data and research initiatives.

Subd. 8. **Contracts and grants.** To carry out the duties assigned in sections 62J.301 to 62J.42, 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.

History: *1995 c 234 art 5 s 8*

62J.322 PROVIDER INFORMATION PILOT STUDY.

The commissioner 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: (i) statistical validity of the data; (ii) public need for the data; (iii) estimated expense of collecting

and reporting the data; and (iv) usefulness of the data to identify barriers and opportunities to improve quality care provision within health plan companies.

History: *1995 c 234 art 5 s 9*

62J.33 [Repealed, 1995 c 234 art 5 s 24]

62J.34 [Repealed, 1995 c 234 art 5 s 24]

62J.35 [Repealed, 1995 c 234 art 5 s 24]

62J.37 COST CONTAINMENT 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 1996 by April 1, 1997. Each April 1 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: *1995 c 234 art 5 s 10*

62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for each calendar year. 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, may be provided separately for the following categories or for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs.

(c) The commissioner may collect information on:

(1) premiums, benefit levels, managed care procedures, and other features of health plan companies;

(2) prices, 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 health plan companies, including information on prices, costs, expenditures, and utilization.

(d) All group purchasers shall provide the required data using a uniform format and uniform definitions, as prescribed by the commissioner.

History: *1995 c 234 art 5 s 11*

62J.40 COST CONTAINMENT DATA FROM STATE AGENCIES AND OTHER GOVERNMENTAL UNITS.

(a) All 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 unaggre-

gated 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.

(b) For purposes of estimating total health care spending as provided in section 62J.301, subdivision 4, clause (c), all local governmental units shall provide expenditure data to the commissioner. The commissioner shall consult with representatives of the affected local government units in establishing definitions, reporting formats, and reporting time frames. As much as possible, the data shall be collected in a manner that ensures that the data collected is consistent with data collected from the private sector and minimizes the reporting burden to local government.

History: *1995 c 234 art 5 s 12*

62J.41 DATA FROM PROVIDERS.

Subdivision 1. **Cost containment 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 or by groups of payers, 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.

The commissioner may, by rule, modify the data submission categories listed above if the commissioner determines that this will reduce the reporting burden on providers without having a significant negative effect on necessary data collection efforts.

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 commissioners of health and revenue shall have the authority to share data collected pursuant to this section.

Subd. 3. [Repealed, 1995 c 234 art 5 s 24]

Subd. 4. [Repealed, 1995 c 234 art 5 s 24]

History: *1995 c 234 art 5 s 13,14*

62J.44 [Repealed, 1995 c 234 art 5 s 24]

62J.45 [Repealed, 1995 c 234 art 5 s 24]

NOTE: Subdivision 8 was also amended by Laws 1995, chapter 248, article 10, section 15, to read as follows:

"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 and staff may participate in the following plans for employees in the unclassified service: the state retirement plan, the state deferred compensation plan, and the coverages in section 43A.24, subdivision 2. The attorney general shall provide legal services to the board."

62J.451 MINNESOTA HEALTH DATA INSTITUTE.

Subdivision 1. **Statement of purpose.** It is the intention of the legislature to create a partnership between the public and the private sectors for the coordination of efforts related to the collection, analysis, and dissemination of cost, access, quality, utilization, and other performance data, to the extent administratively efficient and effective.

The Minnesota health data institute shall be a partnership between the commissioner of health and a board of directors representing group purchasers, health care providers, and consumers.

Subd. 2. **Definitions.** For purposes of this section and section 62J.452, the following definitions apply.

(a) "Analysis" means the identification of selected data elements, a description of the methodology used to select or analyze those data elements, and any other commentary, conclusions, or other descriptive material that the health data institute determines is appropriately included, all of which is undertaken by the health data institute for one or more of the purposes or objectives set forth in subdivisions 1 and 3, or by other authorized researchers pursuant to section 62J.452, subdivision 6.

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

(c) "Contractor" means an agent, association, or other individual or entity that has entered into an agreement with an industry participant, as defined in section 62J.452, subdivision 2, paragraph (i), to act on behalf of that industry participant for purposes of fulfilling the data collection and reporting activities established under this chapter.

(d) "Database" means a compilation of selected data elements by the health data institute for the purpose of conducting an analysis or facilitating an analysis by another party.

(e) "Electronic data interchange system" or "EDI system" means the electronic data system developed, implemented, maintained, or operated by the health data institute, as permitted by subdivisions 3, clause (2), and 5, according to standards adopted by the health data institute.

(f) "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.

(g) "Group purchaser" has the definition provided in section 62J.03, subdivision 6.

(h) "Health data institute" means the public–private partnership between the commissioner of health and the board of directors established under this section.

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

(j) "Industry participant" means any group purchaser, employers with employee health benefit plans, regardless of the manner in which benefits are provided or paid for under the plan, provider, or state agency or political subdivision, with the exception of professional licensing boards or law enforcement agencies.

(k) "Industry participant identifying data" means any data that identifies a specific industry participant directly, or which identifies characteristics which reasonably could uniquely identify such specific industry participant circumstantially. For purposes of this definition, an industry participant is not "directly identified" by the use of a unique identification number, provided that the number is coded or encrypted through a reliable system that can reasonably assure that such numbers cannot be traced back by an unauthorized person to determine the identity of an industry participant with a particular number.

(l) "Patient" is an individual as defined in section 13.02, subdivision 8, except that "patient" does not include any industry participant acting as an industry participant rather than as a consumer of health care services or coverage.

(m) "Patient identifying data" means data that identifies a patient directly, or which identifies characteristics which reasonably could uniquely identify such specific patients circumstantially. For purposes of this definition, a patient is not "directly identified" by the use of a unique identification number, provided that the number is coded or encrypted through a reliable system that can reasonably assure that such numbers cannot be traced back by an unauthorized person to determine the identity of a patient with a particular number.

(n) "Performance" means the degree to which a health plan company, provider organization, or other entity delivers quality, cost–effective services compared to other similar entities, or to a given level of care set as a goal to be attained.

(o) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

(p) "Roster data" with regard to the enrollee of a health plan company or group purchaser means an enrollee's name, address, telephone number, date of birth, gender, and enrollment status under a group purchaser's health plan. "Roster data" with regard to a patient of a provider means the patient's name, address, telephone number, date of birth, gender, and date or dates treated, including, if applicable, the date of admission and the date of discharge.

Subd. 3. **Objectives of the health data institute.** (a) The health data institute shall:

(1) develop a data collection plan that provides coordination for public and private sector data collection efforts related to the performance measurement and improvement of the health care delivery system;

(2) establish an electronic data interchange system that may be used by the public and private sectors to exchange health care data in a cost–efficient manner;

(3) develop a mechanism to collect, analyze, and disseminate information for comparing the cost and quality of health care delivery system components, including health plan companies and provider organizations;

(4) develop policies and procedures to protect the privacy of individual–identifiable data, and to assure appropriate access to and disclosure of information specific to individual health plan companies and provider organizations collected pursuant to this section; and

(5) use and build upon existing data sources and performance 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.

(b) In carrying out its responsibilities, the health data institute may contract with private sector organizations currently collecting data on specific health–related areas of interest to the health data institute, in order to achieve maximum efficiency and cost–effectiveness. The health data institute may establish links between the data collected and maintained by the health data institute and private sector data through the health data institute's electronic data interchange system, and may implement methods to streamline data collection in order to reduce public and private sector administrative costs. The health data institute may use or establish links with public sector data, such as that existing for medical assistance and Medicare, to the extent permitted by state and federal law. The health data institute may also recommend methods to streamline public sector data collection in order to reduce public and private sector administrative costs.

(c) Any contract with a private sector entity must require the private sector entity to maintain the data collected according to the applicable data privacy provisions, as provided in section 62J.452.

Subd. 4. **Data collection plan.** (a) The health data institute shall develop a plan that:

(1) identifies the health care data needs of consumers, group purchasers, providers, and the state regarding the performance of health care delivery system components including health plan companies and provider organizations;

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

(3) identifies the data needed for the health data institute to carry out the duties assigned in this section. The plan must take into consideration existing data sources and data sources that can easily be made uniform for links to other datasets.

(b) This plan shall be updated on an annual basis.

Subd. 5. **Health care electronic data interchange system.** (a) The health data institute shall establish an electronic data interchange 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. This public–private information system shall be developed to make health care claims processing

and financial settlement transactions more efficient and to provide an efficient, unobtrusive method for meeting the shared electronic data interchange needs of consumers, group purchasers, providers, and the state.

(b) The health data institute shall operate the Minnesota center for health care electronic data interchange established in section 62J.57, and shall integrate the goals, objectives, and activities of the center with those of the health data institute's electronic data interchange system.

Subd. 6. **Performance measurement information.** (a) The health data institute shall develop and implement a performance measurement plan to analyze and disseminate health care data to address the needs of consumers, group purchasers, providers, and the state for performance measurement at various levels of the health care system in the state. The plan shall include a mechanism to:

(1) provide comparative information to consumers, purchasers, and policymakers for use in performance assessment of health care system components, including health plan companies and provider organizations;

(2) complement and enhance, but not replace, existing internal performance improvement efforts of health care providers and plans; and

(3) reduce unnecessary administrative costs in the health care system by eliminating duplication in the collection of data for both evaluation and improvement efforts.

(b) Performance measurement at the provider organization level may be conducted on a condition–specific basis. Criteria for selecting conditions for measurement may include:

(1) relevance to consumers and purchasers;

(2) prevalence of conditions;

(3) costs related to diagnosis and treatment;

(4) demonstrated efficacy of treatments;

(5) evidence of variability in management;

(6) existence of risk adjustment methodologies to control for patient and other risk factors contributing to variation in cost and quality;

(7) existence of practice guidelines related to the condition; and

(8) relevance of the condition to public health goals.

(c) Performance measurement on a condition–specific basis may consider multiple dimensions of performance, including, but not limited to:

(1) accessibility;

(2) appropriateness;

(3) effectiveness, including clinical outcomes, patient satisfaction, and functional status; and

(4) efficiency.

(d) Collection of data for condition–specific performance measurement may be conducted at the patient level. Encounter–level data collected for this purpose may include unique identifiers for patients, providers, payers, and employers in order to link episodes of care across care settings and over time. The health data institute must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.452 and 144.335.

Subd. 6a. **Health plan company performance measurement.** As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of health plan companies, and to disseminate this information through reports and other means to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452.

Subd. 6b. **Consumer surveys.** (a) The health data institute shall develop and implement a mechanism for collecting comparative data on consumer perceptions of the health care system, including consumer satisfaction, through adoption of a standard consumer survey. 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 health data institute, in consultation with the health care commission, shall determine a mechanism for the inclusion of the uninsured. This consumer survey may be conducted every two years. A focused survey may be conducted on the off years. Health plan companies and group purchasers shall provide to the health data institute roster data as defined in subdivision 2, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this survey. This roster data provided by the health plan companies and group purchasers is classified as provided under section 62J.452. The health 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 performance reports specified in subdivision 6a, and in other reports developed and disseminated by the health data institute and the commissioner. The raw, unaggregated data is classified as provided under section 62J.452, and may be made available by the health data institute to the extent permitted under section 62J.452. The health data institute shall provide raw, unaggregated data to the commissioner. 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 health 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 health 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, 1996.

Subd. 6c. **Provider organization performance measurement.** As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of hospitals and other provider organizations, and to disseminate this information to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452. Data to be collected may include structural characteristics including staff–mix and nurse–patient ratios. In selecting additional data for collection, the health data institute may 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. 7. **Dissemination of reports; other information.** (a) The health data institute shall establish a mechanism for the dissemination of reports and other information to consumers, group purchasers, health plan companies, providers, and the state. When applicable, the health data institute shall coordinate its dissemination of information responsibilities with those of the commissioner, to the extent administratively efficient and effective.

(b) The health data institute may require those requesting data from its databases to contribute toward the cost of data collection through the payments of fees.

(c) The health data institute shall not allow a group purchaser or health care provider to use or have access to the electronic data interchange system or to access data under section 62J.452, subdivision 6 or 7, unless the group purchaser or health care provider cooperates with the data collection efforts of the health data institute by submitting or making available

through the EDI system or other means all data requested by the health data institute. The health data institute shall prohibit group purchasers and health care providers from transferring, providing, or sharing data obtained from the health data institute under section 62J.452, subdivision 6 or 7, with a group purchaser or health care provider that does not cooperate with the data collection efforts of the health data institute.

Subd. 8. **Annual report.** (a) The health data institute shall submit to the chairs of the senate joint crime prevention and judiciary subcommittee on privacy, the house of representatives judiciary committee, the legislative commission on health care access, the commissioner, and the governor a report on the activities of the health data institute by February 1 of each year beginning February 1, 1996. The report shall include:

(1) a description of the data initiatives undertaken by the health data institute, including a statement of the purpose and a summary of the results of the initiative;

(2) a description of the steps taken by the health data institute to comply with the confidentiality requirements of this section and other applicable laws, and of the health data institute's internal policies and operating procedures relating to data privacy and confidentiality; and

(3) a description of the actions taken by the health data institute to ensure that the EDI system being established pursuant to section 62J.451, subdivision 3, clause (2), and subdivision 5, protects the confidentiality requirements of this section and other applicable laws.

(b) If the health data institute amends or adopts an internal policy or operating procedure relating to data privacy and confidentiality, it shall submit copies of such policy or procedure within 30 days of its adoption to the public officials identified in this subdivision.

Subd. 9. **Board of directors.** The health data 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 and Blue Shield of Minnesota, 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 health care 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. 10. **Terms; compensation; removal; and vacancies.** The board is governed by section 15.0575.

Subd. 11. **Statutory governance.** The health data institute is subject to chapter 13 and section 471.705 but is not otherwise subject to laws governing state agencies except as specifically provided in this chapter.

Subd. 12. **Staff.** The board may hire an executive director. The executive director and other health data institute staff are not state employees but are covered by section 3.736. The executive director and other health data institute staff may participate in the following plans for employees in the unclassified service until January 1, 1996: the state retirement plan, the state deferred compensation plan, and the health, dental, and life insurance plans. The attorney general shall provide legal services to the board.

Subd. 13. **Federal and other grants.** The health data institute may seek federal funding and funding from private and other nonstate sources for the initiative required by the board.

Subd. 14. **Contracts.** To carry out the duties assigned in this section, the health data institute may contract with private sector entities. Any contract must require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data and any other applicable provision specified in section 62J.452.

Subd. 15. **Nonlimiting.** Nothing in this section shall be construed to limit the powers granted to the commissioner of health in chapter 62D, 62N, 144, or 144A.

Subd. 16. **Clarification of intent.** This section is intended to provide the health data institute with primary responsibility for establishing a data collection plan, establishing an electronic data interchange system, measuring performance at the provider organization and health plan company levels, collecting condition–specific data, developing and administering consumer surveys, and performing other duties specifically assigned in this section. The commissioner of health may perform these duties only if the commissioner determines that these duties will not be performed by the health data institute.

History: *1995 c 234 art 5 s 15*

62J.452 PROTECTION OF PRIVACY AND CONFIDENTIALITY OF HEALTH CARE DATA.

Subdivision 1. **Statement of purpose.** The health data institute shall adopt data collection, analysis, and dissemination policies that reflect the importance of protecting the right of privacy of patients in their health care data in connection with each data initiative that the health data institute intends to undertake.

Subd. 2. **Data classifications.** (a) Data collected, obtained, received, or created by the health data institute shall be private or nonpublic, as applicable, unless given a different classification in this subdivision. Data classified as private or nonpublic under this subdivision may be released or disclosed only as permitted under this subdivision and under the other subdivisions referenced in this subdivision. For purposes of this section, data that identify individual patients or industry participants are private data on individuals or nonpublic data, as appropriate. Data not on individuals are nonpublic data. Notwithstanding sections 13.03, subdivisions 6 to 8; 13.10, subdivisions 1 to 4; and 138.17, data received by the health data institute shall retain the classification designated under this chapter and shall not be disclosed other than pursuant to this chapter. Nothing in this subdivision prevents patients from gaining access to their health record information pursuant to section 144.335.

(b) When industry participants, as defined in section 62J.451, are required by statute to provide, either directly or through a contractor, as defined in section 62J.451, subdivision 2, paragraph (c), patient identifying data to the commissioner pursuant to this chapter or to the health data institute pursuant to section 62J.451, the industry participant or its contractor shall be able to provide the data with or without patient consent, and may not be held liable for doing so.

(c) When an industry participant submits patient identifying data to the health data institute, and the data is submitted to the health data institute in electronic form, or through other electronic means including, but not limited to, the electronic data interchange system defined in section 62J.451, the industry participant shall submit the patient identifying data in encrypted form, using an encryption method supplied or specified by the health data institute. Submission of encrypted data as provided in this paragraph satisfies the requirements of section 144.335, subdivision 3b.

(d) Patient identifying data may be disclosed only as permitted under subdivision 3.

(e) Industry participant identifying data which is not patient identifying data may be disclosed only by being made public in an analysis as permitted under subdivisions 4 and 5 or through access to an approved researcher, industry participant, or contractor as permitted under subdivision 6 or 7.

(f) Data that is not patient identifying data and not industry participant identifying data is public data.

(g) Data that describes the finances, governance, internal operations, policies, or operating procedures of the health data institute, and that does not identify patients or industry participants or identifies them only in connection with their involvement with the health data institute, is public data.

Subd. 3. **Patient identifying data.** (a) The health data institute must not make public any analysis that contains patient identifying data.

(b) The health data institute may disclose patient identifying data only as follows:

(1) to research organizations that meet the requirements set forth in subdivision 6, paragraph (a), but only to the extent that such disclosure is also permitted by section 144.335, subdivision 3a, paragraph (a); or

(2) to a contractor of, or vendor of services to the health data institute for the purposes of conducting a survey or analysis, provided that such contractor or vendor agrees to comply with all data privacy requirements applicable to the health data institute, and to destroy or return to the health data institute all copies of patient identifying data in the possession of such contractor or vendor upon completion of the contract.

Subd. 4. **Analysis to be made public by the health data institute.** (a) Notwithstanding the classification under subdivision 2 or other provision of state law of data included or used in an analysis, the health data institute may make public data in an analysis pursuant to this subdivision and subdivision 5. Such analysis may include industry participant identifying data but must not include patient identifying data. In making its determination as to whether to make an analysis or the data used in the analysis public, the health data institute shall consider and determine, in accordance with policies and criteria developed by the health data institute, that the data and analysis are sufficiently accurate, complete, reliable, valid, and as appropriate, case–mixed and severity adjusted, and statistically and clinically significant.

(b) Prior to making an analysis public, the health data institute must provide to any industry participant identified in the analysis an opportunity to use the fair hearing procedure established under subdivision 5.

(c) Accompanying an analysis made public by the health data institute, the health data institute shall also make public descriptions of the database used in the analysis, the methods of adjusting for case mix and severity, and assuring accuracy, completeness, reliability, and statistical and clinical significance, as appropriate, and appropriate uses of the analysis and related analytical data, including precautionary statements regarding the limitations of the analysis and related analytical data.

Subd. 5. **Fair hearing procedure prior to making an analysis public.** (a) The health data institute may not make public an analysis that identifies an industry participant unless the health data institute first complies with this subdivision. A draft of the portion of the analysis that identifies an industry participant must be furnished upon an industry participant's request to that industry participant prior to making that portion of the analysis public. Such draft analysis is private or nonpublic, as applicable. The industry participants so identified have the right to a hearing, at which the industry participants or their contractors, as defined in section 62J.451, subdivision 2, paragraph (c), may object to or seek modification of the analysis. The cost of the hearing shall be borne by the industry participant requesting the hearing.

(b) The health data institute shall establish the hearing procedure in writing. The hearing procedure shall include the following:

(1) the provision of reasonable notice of the health data institute's intention to make such analysis public;

(2) an opportunity for the identified industry participants to submit written statements to the health data institute board of directors or its designate, to be represented by a contractor, as defined in section 62J.451, subdivision 2, paragraph (c), or other individual or entity acting on behalf of and chosen by the industry participant for this purpose, and to append a statement to such analysis to be included with it when and if the analysis is made public; and

(3) access by the identified industry participants to industry participant identifying data, but only as permitted by subdivision 6 or 7.

(c) The health data institute shall make the hearing procedure available in advance to industry participants which are identified in an analysis. The written hearing procedure is public data. The following data related to a hearing is public:

(1) the parties involved;

(2) the dates of the hearing; and

(3) a general description of the issue and the results of the hearing.

All other data relating to the hearing is private or nonpublic.

Subd. 6. **Access by approved researchers to data that identifies industry participants but does not identify patients.** (a) The health data institute shall provide access to industry participant identifying data, but not patient identifying data, once those data are in analyzable form, upon request to research organizations or individuals that:

(1) have as explicit goals research purposes that promote individual or public health and the release of research results to the public as determined by the health data institute according to standards it adopts for evaluating such goals;

(2) enforce strict and explicit policies which protect the confidentiality and integrity of data as determined by the health data institute according to standards it adopts for evaluating such policies;

(3) agree not to make public, redisclose, or transfer the data to any other individual or organization, except as permitted under paragraph (b);

(4) demonstrate a research purpose for the data that can be accomplished only if the data are provided in a form that identifies specific industry participants as determined by the health data institute according to standards it adopts for evaluating such research purposes; and

(5) agree to disclose analysis in a public forum or publication only pursuant to subdivisions 4 and 5 and other applicable statutes and the health data institute's operating rules governing the making of an analysis public by the health data institute.

(b) Contractors of entities that have access under paragraph (a) may also have access to industry participant identifying data, provided that the contract requires the contractor to comply with the confidentiality requirements set forth in this section and under any other statute applicable to the entity.

Subd. 7. **Access by industry participants to data that identifies industry participants but does not identify patients.** (a) The health data institute may provide, to an industry participant, data that identifies that industry participant or other industry participants, to the extent permitted under this subdivision. An employer or an employer purchasing group may receive data relating to care provided to patients for which that employer acts as the payer. A health plan company may receive data relating to care provided to enrollees of that health plan company. A provider may receive data relating to care provided to patients of that provider.

(b) An industry participant may receive data that identifies that industry participant or other industry participants and that relates to care purchased or provided by industry participants other than the industry participant seeking the data. These data must be provided by the health data institute only with appropriate authorization from all industry participants identified.

(c) The health data institute must not provide access to any data under this subdivision that is patient identifying data as defined in section 62J.451, subdivision 2, paragraph (m), even if providing that data would otherwise be allowed under this subdivision.

(d) To receive data under this subdivision, an industry participant must cooperate with the health data institute as provided under section 62J.451, subdivision 7, paragraph (c).

(e) Contractors of entities that have access under paragraph (b) may have access to industry participant identifying data, provided that the contract requires the contractor to comply with the confidentiality requirements set forth in this section and under any other statute applicable to the entity.

Subd. 8. **Status of data on the electronic data interchange system.** (a) Data created or generated by or in the custody of an industry participant, and transferred electronically by that industry participant to another industry participant using the EDI system developed, implemented, maintained, or operated by the health data institute, as permitted by section 62J.451, subdivision 3, clause (2), and subdivision 5, is not subject to this section or to chapter 13 except as provided below.

(b) Data created or generated by or in the custody of an industry participant is subject to the privacy protections applicable to the data, including, but not limited to, chapter 13 with respect to state agencies and political subdivisions, the Minnesota insurance fair information

reporting act with respect to industry participants subject to it, and section 144.335, with respect to providers and other industry participants subject to such section.

Subd. 9. **Authorization of state agencies and political subdivisions to provide data.** (a) Notwithstanding any limitation in chapter 13 or section 62J.321, subdivision 5, regarding the disclosure of not public data, all state agencies and political subdivisions, including, but not limited to, municipalities, counties, and hospital districts may provide not public data relating to health care costs, quality, or outcomes to the health data institute for the purposes set forth in section 62J.451.

(b) Data provided by the commissioner pursuant to paragraph (a) may not include patient identifying data as defined in section 62J.451, subdivision 2, paragraph (m). For data provided by the commissioner of health pursuant to paragraph (a), the health data institute and anyone receiving the data from the health data institute, is prohibited from unencrypting or attempting to link the data with other patient identifying data sources.

(c) Any data provided to the health data institute pursuant to paragraph (a) shall retain the same classification that it had with the state agency or political subdivision that provided it. The authorization in this subdivision is subject to any federal law restricting or prohibiting such disclosure of the data described above.

(d) Notwithstanding any limitation in chapter 13 or this section and section 62J.451 regarding the disclosure of nonpublic and private data, the health data institute may provide nonpublic and private data to any state agency that is a member of the board of the health data institute. Any such data provided to a state agency shall retain nonpublic or private classification, as applicable.

Subd. 10. **Civil remedies.** Violation of any of the confidentiality requirements set forth in subdivision 3; 4, paragraph (a); 6; or 7, by the health data institute, its board members, employees and contractors, any industry participant, or by any other person shall be subject to section 13.08, including, but not limited to, the immunities set forth in section 13.08, subdivisions 5 and 6. The health data institute shall not be liable for exercising its discretion in a manner that is not an abuse of discretion with respect to matters under its discretion by this section or section 62J.451. The health data institute shall not be liable for the actions of persons not under the direction and control of the health data institute, where it has performed its responsibilities to protect data privacy by complying with the requirements of this section and other applicable laws with regard to the disclosure of data. The remedies set forth in this section do not preclude any person from pursuing any other remedies authorized by law.

Subd. 11. **Penalties.** (a) Any person who willfully violates the confidentiality requirements set forth in subdivision 3; 4, paragraph (a); 6; or 7, shall be guilty of a misdemeanor.

(b) Any person who willfully violates the confidentiality requirements of subdivision 3, 4, 6, 7, 8, or 9, by willfully disclosing patient or industry participant identifying data for compensation or remuneration of any kind or for the purpose of damaging the reputation of any patient or industry participant or any other malicious purpose, shall be guilty of a gross misdemeanor.

Subd. 12. **Discoverability of health data institute data.** (a) Data created, collected, received, maintained, or disseminated by the health data institute shall not be subject to discovery or introduction into evidence in any civil or criminal action. Data created, collected, received, maintained, or disseminated by the health data institute that is otherwise available from original sources is subject to discovery from those sources and may be introduced into evidence in civil or criminal actions in accordance with and subject to applicable laws and rules of evidence and civil or criminal procedure, as applicable.

(b) Information related to submission of data to the health data institute by industry participants or contractors of industry participants is not discoverable from the health data institute, the industry participants, the contractors, or any other person or entity, in any civil or criminal action. Discovery requests prohibited under this paragraph include, but are not limited to, document requests or interrogatories that ask for "all data provided to the Minnesota health data institute."

History: *1995 c 234 art 5 s 16*

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144.802 are eligible for reimbursement under health plan companies. The commissioner shall require health plan companies 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 a health plan company, if approved by a designated representative of a health plan company 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: *1995 c 234 art 8 s 11*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) On and after January 1, 1998, 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, 1998, 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, 1998, 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, 1998, 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: *1995 c 234 art 5 s 17*

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.321, subdivision 1. 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: *1995 c 234 art 5 s 18*

62J.58 IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I industry participants and 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.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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.

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II 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.

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: *1995 c 234 art 5 s 19*

62J.65 [Repealed, 1995 c 234 art 8 s 57]

SENIOR DRUG DISCOUNT PROGRAM

62J.66 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of this section and section 62J.68, the following definitions apply.

Subd. 2. **Discounted price.** "Discounted price" means the lesser of the average wholesale price for a prescription drug minus 20 percent or the usual and customary retail price, including any dispensing fee, minus five percent.

Subd. 3. **Eligible senior.** "Eligible senior" means a senior citizen eligible for the senior drug discount program under section 62J.68, subdivision 3.

Subd. 4. **Senior citizen.** "Senior citizen" means a resident of Minnesota who is age 65 or older.

Subd. 5. **Senior drug discount program.** "Senior drug discount program" means the program established in section 62J.68.

Subd. 6. **Participating drug manufacturer.** "Participating drug manufacturer" means any manufacturer who agrees to voluntarily participate in the senior drug discount program.

Subd. 7. **Participating claims processing companies.** "Participating claims processing companies" means entities, including, but not limited to, pharmacy benefit management companies, that are awarded a contract by the department of administration to provide on–line services to process payments to participating pharmacies.

Subd. 8. **Average manufacturer price.** "Average manufacturer price" has the meaning assigned to the term by the Secretary of Health and Human Services for purposes of the federal drug rebate program established under the Omnibus Budget Reconciliation Act of 1990 and section 1927 of the Social Security Act.

History: *1995 c 234 art 6 s 1*

62J.68 SENIOR DRUG DISCOUNT PROGRAM.

Subdivision 1. **Establishment and administration.** (a) The commissioner of administration shall award a contract or contracts to claims processing companies to process payments to participating pharmacies. The contract must include:

(1) provisions for participating manufacturers to provide discount payments, through participating claims processing companies, equal to four percent of the average manufacturer price; and

(2) quality assurance and verification procedures and authority to conduct audits of pharmacy claims as necessary to ensure that pharmacy reimbursement payments are appropriate and justified.

(b) The commissioner of administration may establish an expert panel to assist in the development of the request for proposal for awarding the contract or contracts to process payments for the senior drug discount program.

Subd. 2. **Participating manufacturers.** Participating manufacturers agree to:

(1) pay participating pharmacies through the claims processor an amount equal to four percent of the average manufacturer price;

(2) process discount payments through participating claims processing companies according to the timelines used under the medical assistance program;

(3) pay administrative fees established under subdivision 7.

Subd. 3. **Participating pharmacies.** Participating pharmacies agree to:

(1) provide eligible seniors the discounted price established by the senior drug discount program;

(2) accept payments from participating claims processing companies equal to four percent of the average manufacturer price; and

(3) not charge eligible seniors a dispensing fee greater than $3.

Subd. 4. **Enrollment.** The commissioner of human services shall determine eligibility as specified in subdivision 5 and enroll senior citizens in the senior drug discount program. The commissioner may use volunteers to assist in eligibility and enrollment duties. The commissioner of human services shall post the eligibility of the enrollees to the Medicaid Management Information System (MMIS) where it can be assessed by participating pharmacies through the department's eligibility verification system and point–of–sale system upon presentation of the enrollee's Minnesota health care programs card.

Subd. 5. **Eligibility.** (a) Senior citizens are eligible for the program if:

(1) their household income does not exceed 200 percent of the federal poverty guidelines;

(2) they are enrolled in Medicare Part A and Part B;

(3) they do not have coverage for prescription drugs under a health plan, as defined in section 62Q.01, subdivision 3;

(4) they do not have coverage for prescription drugs under a Medicare supplement plan, as defined in sections 62A.31 to 62A.44, or policies, contracts, or certificates that supplement Medicare issued by health maintenance organizations or those policies, contracts, or certificates governed by section 1833 or 1976 of the federal Social Social Security Act, United States Code, title 42, section 1395, et seq., as amended, or coverage for prescription drugs under medical assistance under chapter 256B, general assistance medical care under chapter 256D, MinnesotaCare, or the qualified medical beneficiaries program;

(5) they meet the residency requirements established under section 256.9359; and

(6) they do not have coverage for prescription drugs under medical assistance, general assistance medical care, MinnesotaCare, or the qualified Medicare beneficiary program.

(b) The commissioner of human services shall provide each eligible senior with a Minnesota health care programs card indicating enrollment in the senior drug discount program. Eligible seniors must present this card to the participating pharmacy in order to receive the discounted price.

Subd. 6. **Enrollment fee.** The commissioner of human services may establish an annual enrollment fee of $5 for purposes of administering the senior drug discount program. The fees shall be deposited in a special revenue account for the purpose of administration of enrollment to the senior drug discount program. This account shall be exempt from paying statewide and agency indirect costs as required under section 16A.127.

Subd. 7. **Administrative fee.** The commissioner of administration may authorize a claims processing contractor to charge a fixed claims processing fee not to exceed ten cents for each prescription drug provided to participating seniors under this section. In the event the commissioner authorizes a claims processing fee, one–half of the fee must be paid by the participating manufacturer and one–half by the participating pharmacy.

Subd. 8. **Disease management for drug therapy.** The commissioner of human services may establish a disease management program for drug therapy for eligible senior citizens. The commissioner may seek grants and donations from drug manufacturers, drug wholesalers, and other nonstate entities to establish and administer this disease management program.

Subd. 9. **Senior drug discount program evaluation.** The commissioners of human services and health, in consultation with the commissioner of administration, shall study the efficiency and effectiveness of the senior drug discount program. The commissioners shall examine methods of encouraging participation by drug manufacturers and pharmacies in the program and any program modifications necessary to effectively serve eligible senior citizens. The commissioners shall present a progress report on the program to the legislature by January 15, 1996, and recommendations for program changes to the legislature by January 15, 1997.

History: *1995 c 234 art 6 s 2*