CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.01 FINDINGS.

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

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

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

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

History: *1989 c 327 s 1*

COST CONTROLS

62J.015 PURPOSE.

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

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

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

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

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

62J.016 GOALS OF RESTRUCTURING.

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

History: *1994 c 625 art 1 s 1*

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system. 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.

History: *1994 c 625 art 1 s 2; 1995 c 234 art 3 s 1; 1997 c 225 art 2 s 9*

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

62J.03 DEFINITIONS.

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

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

Subd. 3. [Repealed, 1997 c 225 art 2 s 63]

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

Subd. 5. **Cost-effective.** "Cost-effective" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are

justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies.

Subd. 6. **Group purchaser.** "Group purchaser" means a person or organization that purchases health care services on behalf of an identified group of persons, regardless of whether the cost of coverage or services is paid for by the purchaser or by the persons receiving coverage or services, as further defined in rules adopted by the commissioner. "Group purchaser" includes, but is not limited to, community integrated service networks; health insurance companies, health maintenance organizations, nonprofit health service plan corporations, and other health plan companies; employee health plans offered by self-insured employers; trusts established in a collective bargaining agreement under the federal Labor-Management Relations Act of 1947, United States Code, title 29, section 141, et seq.; the Minnesota comprehensive health association; group health coverage offered by fraternal organizations, professional associations, or other organizations; state and federal health care programs; state and local public employee health plans; workers' compensation plans; and the medical component of automobile insurance coverage.

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

Subd. 8. **Provider or health care provider.** "Provider" or "health care provider" means a person or organization other than a nursing home that provides health care or medical care services within Minnesota for a fee and is eligible for reimbursement under the medical assistance program under chapter 256B. For purposes of this subdivision, "for a fee" includes traditional fee-for-service arrangements, capitation arrangements, and any other arrangement in which a provider receives compensation for providing health care services or has the authority to directly bill a group purchaser, health carrier, or individual for providing health care services. For purposes of this subdivision, "eligible for reimbursement under the medical assistance program" means that the provider's services would be reimbursed by the medical assistance program if the services were provided to medical assistance enrollees and the provider sought reimbursement, or that the services would be eligible for reimbursement under medical assistance except that those services are characterized as experimental, cosmetic, or voluntary.

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

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

History: *1992 c 549 art 1 s 2; 1993 c 345 art 3 s 1; art 4 s 1; art 6 s 1; 1994 c 625 art 8 s 14,15; 1997 c 225 art 2 s 62*

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

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

(b) The commissioner shall set the following annual cost containment goals for public and private spending on health care services for Minnesota residents:

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

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

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

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

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

The commissioner shall adjust the cost containment goal set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993, to December 31, 1993.

(c) The commissioner shall publish:

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

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

(3) the Centers for Medicare and Medicaid Services forecast for total growth in the national health care expenditures.

Subd. 1a. **Cost containment goals.** The commissioner shall publish the final adjusted cost containment goal in the State Register by January 31 of the year that the cost containment goal is to be in effect. The adjusted cost containment goal must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected cost containment goal 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 cost containment goal. 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 cost containment goals within the overall health care reform strategy.

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

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

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

Subd. 3. **Cost containment duties.** The commissioner shall:

(1) establish statewide and regional cost containment goals for total health care spending under this section and collect data as described in sections 62J.38 to 62J.41 to monitor statewide achievement of the cost containment goals;

(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 the cost containment goals;

(3) monitor the quality of health care throughout the state and take action as necessary to ensure an appropriate level of quality;

(4) 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 Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

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

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

(7) 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;

(8) 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; and

(9) make the cost containment goal data available to the public in a consumer-oriented manner.

Subd. 4. [Repealed, 1997 c 225 art 2 s 63]

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

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

Subd. 7. [Repealed, 1997 c 225 art 2 s 63]

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

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

History: *1992 c 549 art 1 s 3; 1993 c 247 art 1 s 1-6; 1993 c 345 art 1 s 1; art 3 s 2-4,18; art 5 s 7,8; art 6 s 2,3; 1994 c 625 art 8 s 16-18; 1995 c 234 art 3 s 2; art 5 s 2; 1997 c 150 s 1-3; 1997 c 187 art 1 s 5; 1998 c 254 art 1 s 11; 1999 c 245 art 2 s 2; 2000 c 260 s 83; 2002 c 277 s 32*

62J.041 INTERIM HEALTH PLAN COMPANY COST CONTAINMENT GOALS.

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 cost containment goals for the increase in net expenditures by each health plan company for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b). Health plan companies that are affiliates may elect to meet one combined cost containment goal.

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 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 cost containment goal 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 assess the degree to which savings resulting from the establishment of cost containment goals 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 cost containment goals. 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 a 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 cost containment goal 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 cost containment goal 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 cost containment goal, 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 cost containment goal. 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.

Subd. 7. [Repealed by amendment, 1997 c 150 s 4]

History: *1993 c 345 art 2 s 4; 1994 c 625 art 3 s 4; 1995 c 234 art 3 s 9; 1997 c 150 s 4; 1997 c 225 art 2 s 62*

62J.042 [Repealed, 1997 c 150 s 6]

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

62J.05 [Repealed, 1997 c 225 art 2 s 63]

62J.051 [Repealed, 1997 c 225 art 2 s 63]

62J.06 IMMUNITY FROM LIABILITY.

No member of the health technology advisory 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: *1993 c 247 art 1 s 7; 1995 c 234 art 5 s 3; 1997 c 225 art 2 s 10; 1999 c 245 art 2 s 3*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The legislative commission on health care access reviews the activities of the commissioner of health, the health technology

advisory committee, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

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

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

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

History: *1992 c 549 art 1 s 5; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72; 1997 c 225 art 2 s 11,12; 1999 c 245 art 2 s 4,5*

62J.09 [Repealed, 1999 c 245 art 2 s 6]

62J.15 HEALTH PLANNING.

Subdivision 1. **Health technology advisory committee.** The legislative commission on health care access may convene or authorize the commissioner of health to convene an advisory committee to conduct evaluations of existing research and technology assessments conducted by other entities of new and existing health care technologies as designated by the legislative commission on health care access, the commissioner, or the advisory committee. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies include high-cost drugs, devices, procedures, or processes applied to human health care, such as high-cost transplants and expensive scanners and imagers. The advisory committee is governed by section 15.0575, except that members do not receive per diem payments.

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

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

History: *1992 c 549 art 1 s 7; 1993 c 247 art 1 s 11; 1993 c 345 art 4 s 2,3; 1994 c 465 art 3 s 66; 1997 c 225 art 2 s 14; 2001 c 161 s 12*

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

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

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

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

(3) provide the legislature with scientific evaluations of proposed benefit mandates that utilize health care technologies for a specific use and application;

(4) report the results of the evaluations to the commissioner and the legislative commission on health care access; and

(5) carry out other duties relating to health technology assigned by the legislature or the legislative commission on health care access.

Subd. 1a. **Legislative action.** Nothing in subdivision 1 shall be construed to:

(1) require the legislature to postpone hearings or legislative action on a proposed benefit mandate; or

(2) require the legislature to act in accordance with any recommendations of the health technology advisory committee.

Subd. 2. **Criteria for evaluation.** The health technology advisory committee shall consider the following criteria in assessing or evaluating technologies:

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

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

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

(7) the public health importance;

(8) the level of public and professional demand;

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

(10) the prevalence of the disease or condition.

The committee may give different weights or attach different importance to each of the criteria, depending on the technology being considered. The committee shall consider any additional criteria approved by the commissioner and the legislative commission on health care access. The committee shall present its list of technologies for evaluation to the legislative commission on health care access for review.

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

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

(b) When the evaluation process on a specific technology has been completed, the health technology advisory committee shall submit a preliminary report to the commissioner and the legislative commission on health care access and publish a summary of the preliminary report in the State Register with a notice that written comments may be submitted. The preliminary report must include the results of the technology assessment evaluation, studies and research findings considered in conducting the evaluation, and the health technology advisory committee's summary statement about the evaluation. Any interested persons or organizations may submit to the health technology advisory committee written comments regarding the technology evaluation within 30 days from the date the preliminary report was published in the State Register. The health technology advisory committee's final report on its technology evaluation must be submitted to the commissioner, to the legislature, and to the information clearinghouse. A summary of written comments received by the health technology advisory committee within the 30-day period must be included in the final report.

(c) The reports of the health technology advisory committee should not eliminate or bar new technology.

Subd. 5. **Use of technology evaluation.** (a) The final report on the technology evaluation may be used:

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

(2) by 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 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]

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

Subd. 8. **Repealer.** This section and sections 62J.15 and 62J.156 are repealed effective July 1, 2005.

History: *1993 c 345 art 4 s 4; 1994 c 625 art 3 s 22; 1995 c 234 art 3 s 4; 1997 c 187 art 3 s 16; 1997 c 225 art 2 s 15-20; 1Sp2001 c 9 art 1 s 1; 2002 c 379 art 1 s 113*

62J.156 CLOSED COMMITTEE HEARINGS.

Notwithstanding chapter 13D, the health technology advisory committee may meet in closed session to discuss a specific technology or procedure that involves data received under section 62J.152, subdivision 7, that have been classified as nonpublic data, where disclosure of the data would cause harm to the competitive or economic position of the source of the data.

History: *1993 c 345 art 4 s 5*

62J.17 EXPENDITURE REPORTING.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending

commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

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

(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.

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

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

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

(e) "Health care service" means:

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

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

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

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

(1) acquisition of a unit of medical equipment;

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

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

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

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

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

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

(1) an extracorporeal shock wave lithotripter;

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

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

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

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

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

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

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

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

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

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

Subd. 4. [Repealed, 1993 c 345 art 6 s 26]

Subd. 4a. **Expenditure reporting.** (a) 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) 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) 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) If the provider fails to submit a complete and timely expenditure report, including any additional information requested by the commissioner, the commissioner may make the provider's subsequent major spending commitments subject to the procedures of prospective review and approval under subdivision 6a.

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

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review.

The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

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

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

Subd. 6a. **Prospective review and approval.** (a) 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) 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) 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 health technology advisory committee 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) 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.

Subd. 8. **Radiation therapy facilities.** This subdivision shall apply only to those major spending commitments that are related to the purchase, construction, or leasing of a radiation therapy facility.

(a) The term "provider" shall mean:

(1) a provider as defined in section 62J.03, subdivision 8;

(2) a person or organization that, upon engaging in an activity related to a major spending commitment, will become a provider as defined in section 62J.03, subdivision 8;

(3) an organization under common control with an organization described in clause (1) or (2); or

(4) an organization that manages a person or organization described in clause (1), (2), or (3).

(b) In conducting the retrospective or prospective review, the commissioner shall consider the criteria described in subdivision 5a, paragraph (a), in determining whether the major spending commitment was appropriate. In addition, the commissioner shall consider the following criteria:

(1) the alternatives available to patients in terms of avoiding an unwarranted duplication based on whether additional capacity is needed of services, facilities, or equipment in and around the location of the major spending commitment; and

(2) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the major spending commitment.

(c) In addition to subdivision 6a, paragraph (c), the commissioner has the authority to pursue the following remedies:

(1) assessment of fines against providers violating subdivision 6a, paragraph (a), of up to triple the amount of the major spending commitment;

(2) securing a permanent injunction against providers violating subdivision 6a, paragraph (a), halting the purchase or construction of a facility, prohibiting the operation of a facility, or the providing of a service related to the major spending commitment; and

(3) obtaining a court order to invalidate any purchase agreement, management agreement, lease, or other contract relating to the major spending commitment or the conduct of any activity relating to the major spending commitment.

(d) If a provider fails the retrospective review of a major spending commitment that is identified under this subdivision, the prospective review and approval required under subdivision 6a shall be limited to major spending commitments that are identified under this subdivision.

(e) The provisions of this subdivision do not apply to radiation therapy facilities owned and operated or managed by a hospital licensed under chapter 144.

History: *1992 c 549 art 1 s 8; 1993 c 345 art 6 s 9-11; 1995 c 234 art 8 s 8-10; 1997 c 225 art 2 s 21; 1998 c 254 art 1 s 12; 2000 c 307 s 1*

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

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

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: *1993 c 345 art 5 s 9; 1995 c 234 art 5 s 4*

62J.22 PARTICIPATION OF FEDERAL PROGRAMS.

The commissioner of health shall seek the full participation of federal health care programs under this chapter, including Medicare, medical assistance, veterans administration programs, and other federal programs. The commissioner of human services shall submit waiver requests and take other action necessary to obtain federal approval to allow participation of the medical assistance program. If federal approval is not given for one or more federal programs, data on the amount of health care spending that is collected under section 62J.04 shall be adjusted so that state and regional spending limits take into account the failure of the federal program to participate.

History: *1992 c 549 art 1 s 11; 1997 c 225 art 2 s 22*

62J.23 PROVIDER CONFLICTS OF INTEREST.

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

Subd. 2. **Interim restrictions.** From July 1, 1992, until rules are adopted by the commissioner under this section, the restrictions in the federal Medicare antikickback statutes in section 1128B(b) of the Social Security Act, United States Code, title 42, section 1320a-7b(b), and rules adopted under the federal statutes, apply to all persons in the state, regardless of whether the person participates in any state health care program. The commissioner shall approve a transition plan submitted to the commissioner by January 1, 1993, by a person who is in violation of this section that provides a reasonable time for the person to modify prohibited practices or divest financial interests in other persons in order to come into compliance with this section. Transition plans that identify individuals are private data. Transition plans that do not identify individuals are nonpublic data.

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

Subd. 4. **Chapter 62N networks.** (a) The legislature finds that the formation and operation of community integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and

overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of community integrated service networks. The legislature finds that the federal Medicare antikickback laws should not be interpreted to interfere with the development of community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

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

History: *1992 c 549 art 1 s 12; 1993 c 247 art 1 s 17; 1993 c 345 art 6 s 13; 1994 c 625 art 8 s 23; 1997 c 225 art 2 s 62*

62J.25 MANDATORY MEDICARE ASSIGNMENT.

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

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

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

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

(e) This section does not apply to ambulance services as defined in section 144E.001, subdivision 3, or medical supplies and equipment. A vendor of medical supplies and equipment that does not accept assignment under the federal Medicare program with respect to a purchase or lease of Medicare-covered supplies or equipment shall notify any purchaser who is a Medicare beneficiary and Minnesota resident, prior to the purchase, or at any time upon the request of the purchaser, that the vendor charges an amount in excess of the Medicare-approved amount.

History: *1992 c 549 art 1 s 13; 1997 c 199 s 14; 1997 c 225 art 2 s 23; 1998 c 339 s 1*

62J.29 [Repealed, 1993 c 345 art 6 s 26]

62J.2911 [Repealed, 1997 c 237 s 22]

62J.2912 [Repealed, 1997 c 237 s 22]

62J.2913 [Repealed, 1997 c 237 s 22]

62J.2914 [Repealed, 1997 c 237 s 22]

62J.2915 [Repealed, 1997 c 237 s 22]

62J.2916 [Repealed, 1997 c 237 s 22]

62J.2917 [Repealed, 1997 c 237 s 22]

62J.2918 [Repealed, 1997 c 237 s 22]

62J.2919 [Repealed, 1997 c 237 s 22]

62J.2920 [Repealed, 1997 c 237 s 22]

62J.2921 [Repealed, 1997 c 237 s 22]

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, employers, 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 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.** (a) 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, and the departments of health and commerce;

(3) provide information on coverage options in each 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.

(b) 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.

(c) 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; 1997 c 225 art 2 s 62; 1999 c 245 art 2 s 7*

DATA COLLECTION AND RESEARCH INITIATIVES

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 cost containment goals under section 62J.04, and measuring cost containment goal 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; 1997 c 150 s 5*

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 consistent 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, and group purchasers, 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, or group purchaser until after the institution, group of professionals, individual health care professional, or group purchaser 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. 5a. **Prescription drug price disclosure data.** Notwithstanding subdivisions 1 and 5, data collected under section 62J.381 shall be classified as public data.

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; 1997 c 225 art 2 s 62; 1998 c 407 art 2 s 3*

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, 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; 1997 c 225 art 2 s 62*

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 [Repealed, 1997 c 225 art 2 s 63]

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 must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and 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. Administra-

tive costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. 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. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative 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: *1993 c 345 art 3 s 10; 1994 c 625 art 8 s 28; 1995 c 234 art 5 s 11; 1Sp2001 c 9 art 16 s 4; 2002 c 379 art 1 s 113*

62J.381 PRESCRIPTION DRUG PRICE DISCLOSURE.

By April 1, 1999, and annually thereafter, hospitals licensed under chapter 144 and group purchasers required to file a full report under section 62J.38 and the rules promulgated thereunder, must submit to the commissioner of health the total amount of:

(1) aggregate purchases of or payments for prescription drugs; and

(2) aggregate cash rebates, discounts, other payments received, and any fees associated with education, data collection, research, training, or market share movement, which are received during the previous calendar year from a manufacturer as defined under section 151.44, paragraph (c), or wholesale drug distributor as defined under section 151.44, paragraph (d).

The data collected under this section shall be distributed through the information clearinghouse under section 62J.2930. The identification of individual manufacturers or wholesalers or specific drugs shall not be required under this section.

History: *1998 c 407 art 2 s 4*

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 unaggregated form, for purposes of developing estimates of spending, setting spending limits, and monitoring actual spending. The data must be provided at the times and in the form specified by the commissioner of health.

(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: *1993 c 345 art 3 s 11; 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, 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: *1993 c 345 art 3 s 12; 1994 c 625 art 8 s 29; 1995 c 234 art 5 s 13,14; 1997 c 225 art 2 s 62*

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

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

History: *1993 c 345 art 3 s 13*

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

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

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.** 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.

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, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The health data institute 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.** (a) 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.

(b) The health data institute may conduct consumer surveys that focus on health care provider organizations. Health care provider organizations may provide roster data, as defined in subdivision 2, including names, addresses, and telephone numbers of their patients, to the health data institute for purposes of conducting the surveys. Roster data provided by health care provider organizations under this paragraph are private data on individuals as defined in section 13.02, subdivision 12. Providing data under this paragraph does not constitute a release of health records for purposes of section 144.335, subdivision 3a.

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 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.** (a) The health data institute is governed by a 21-member board of directors consisting of the following 20 voting members:

(1) two representatives of hospitals appointed by the Minnesota Hospital and Health Care Partnership, 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.

(b) In addition, the board consists of one nonvoting member, the commissioner of administration.

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 chapters 13 and 13D 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 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; 1996 c 440 art 1 s 19-21; 1997 c 225 art 2 s 29,62; 1997 c 228 s 1; 1998 c 270 s 2; 1999 c 250 art 1 s 114; 1Sp2001 c 9 art 1 s 2*

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.46 MONITORING AND REPORTS.

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

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

History: *1993 c 345 art 3 s 16; 2001 c 161 s 13*

62J.47 [Repealed, 1999 c 86 art 1 s 83]

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144E.10 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: *1994 c 625 art 4 s 1; 1995 c 234 art 8 s 11; 1997 c 199 s 14*

62J.49 AMBULANCE SERVICES FINANCIAL DATA.

Subdivision 1. **Establishment.** The emergency medical services regulatory board established under chapter 144 shall establish a financial data collection system for all ambulance services licensed in this state. To establish the financial database, the emergency medical services regulatory board may contract with an entity that has experience in ambulance service financial data collection.

Subd. 2. **Data classification.** All financial data collected by the emergency medical services regulatory board shall be classified as nonpublic data under section 13.02, subdivision 9.

History: *1997 c 203 art 2 s 1*

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 CITATION AND PURPOSE.

Subdivision 1. **Citation.** Sections 62J.50 to 62J.61 may be cited as the Minnesota Health Care Administrative Simplification Act of 1994.

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

History: *1994 c 625 art 9 s 1*

62J.51 DEFINITIONS.

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

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

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

Subd. 3a. **Card issuer.** "Card issuer" means the group purchaser who is responsible for printing and distributing identification cards to members or insureds.

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

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

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

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the transaction format developed and approved for implementation in December 1993 and used by providers to request and receive information on the status of a health care claim or encounter that has been submitted to a group purchaser.

Subd. 6b. **Claim submission address.** "Claim submission address" means the address to which the group purchaser requires health care providers, members, or insureds to send health care claims for processing.

Subd. 6c. **Claim submission number.** "Claim submission number" means the unique identification number to identify group purchasers as described in section 62J.54, with its suffix identifying the claim submission address.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the most current version of the uniform dental claim form developed by the American Dental Association.

Subd. 19a. **Uniform explanation of benefits document.** "Uniform explanation of benefits document" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a patient.

Subd. 19b. **Uniform remittance advice report.** "Uniform remittance advice report" means the document associated with and explaining the details of a group purchaser's claim adjudication for services rendered, which is sent to a provider.

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

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

History: *1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22-25; 2000 c 460 s 2,3; 2002 c 307 art 2 s 3; 2002 c 330 s 19*

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

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

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

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); institutional owned or operated outpatient services such as waivered services, hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, including infusion therapy, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

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

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

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

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

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

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

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

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

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

(b) On and after July 1, 1996, state and federal health care programs administered by the department of human services shall accept the HCFA 1450 for community mental health center services and shall accept the HCFA 1500 for freestanding ambulatory surgical center services.

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

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

(e) Personal care attendant and waivered services billed on a fee-for-service basis directly to state and federal health care programs administered by the department of human services shall use either the HCFA 1450 or the HCFA 1500 form, as designated by the department of human services.

History: *1994 c 625 art 9 s 3; 2000 c 460 s 4-6*

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

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

History: *1994 c 625 art 9 s 4*

62J.535 UNIFORM BILLING REQUIREMENTS FOR CLAIM TRANSACTIONS.

Subdivision 1. [Repealed, 2002 c 307 art 2 s 9; 2002 c 330 s 35]

Subd. 1a. **Electronic claim transactions.** Group purchasers, including government programs, not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, that voluntarily agree with providers to accept electronic claim transactions, must accept them in the ANSI X12N 837 standard electronic format as established by federal law. Nothing in this section requires acceptance of electronic claim transactions by entities not covered under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 1b. **Paper claim transactions.** All group purchasers that accept paper claim transactions must accept, and health care providers submitting paper claim transactions must submit, these transactions with use of the applicable medical and nonmedical data code sets specified in the federal electronic claim transaction standards adopted under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections. The paper claim transaction must also be conducted using the uniform billing forms as specified in section 62J.52 and the identifiers specified in section 62J.54, on and after the compliance date required by law. Notwithstanding the above, nothing in this section or other state law prohibits group purchasers not defined as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations

promulgated under those sections, from requiring, as authorized by Minnesota law or rule, additional information associated with a claim submitted by a provider.

Subd. 2. **Compliance.** Subdivision 1a is effective concurrent with the date of required compliance for covered entities established under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time.

History: *1999 c 245 art 2 s 8; 2000 c 483 s 16; 2000 c 488 art 11 s 1; 2002 c 307 art 2 s 4-6,8; 2002 c 330 s 20-22,33*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) Not later than 24 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), 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 (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify health provider organizations no later than 36 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health care providers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for health care provider organizations.

(d) Provider organizations required to have a unique health identifier are:

(1) hospitals licensed under chapter 144;

(2) nursing homes and hospices licensed under chapter 144A;

(3) subacute care facilities;

(4) individual providers organized as a clinic or group practice;

(5) independent laboratory, pharmacy, surgery, radiology, or outpatient facilities;

(6) ambulance services licensed under chapter 144;

(7) special transportation services certified under chapter 174; and

(8) other provider organizations as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

Provider organizations shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only 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.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 2. **Unique identification number for individual health care providers.** (a) Not later than 24 months after the date on which a unique health identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), 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 (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify an individual health care provider no later than 36 months after the date on which a unique health

identifier for health care providers is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health care providers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for individual health care providers.

(d) Individual providers required to have a unique health identifier are:

(1) physicians licensed under chapter 147;

(2) dentists licensed under chapter 150A;

(3) chiropractors licensed under chapter 148;

(4) podiatrists licensed under chapter 153;

(5) physician assistants as defined under section 147A.01;

(6) advanced practice nurses as defined under section 62A.15;

(7) doctors of optometry licensed under section 148.57;

(8) pharmacists licensed under chapter 151;

(9) individual providers who may bill Medicare for medical and other health services as defined in United States Code, title 42, section 1395x(s);

(10) individual providers who are providers for state and federal health care programs administered by the commissioner of human services; and

(11) other individual providers as required by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

Providers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only 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.

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 3. **Unique identification number for group purchasers.** (a) Not later than 24 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers, except as provided in paragraph (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify group purchasers no later than 36 months after the date on which a unique health identifier for employers and health plans is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for health plans and employers adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique identification number for group purchasers.

(d) Group purchasers shall obtain a unique health identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

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

(f) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

Subd. 4. **Unique patient identification number.** (a) Not later than 24 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), 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 (b).

(b) Small health plans, as defined by the federal Secretary of Health and Human Services under United States Code, title 42, section 1320d-4 (1996 and subsequent amendments), shall use a unique identification number to identify each patient who receives health care services in Minnesota no later than 36 months after the date on which a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The unique health identifier for individuals adopted or established by the federal Secretary of Health and Human Services under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), shall be used as the unique patient identification number, except as provided in paragraphs (e) and (f).

(d) 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.

(e) Within the limits of available appropriations, the commissioner shall develop a proposal for an alternate numbering system for patients who do not have or refuse to provide their social security numbers, if:

(1) a unique health identifier for individuals is adopted or established under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments);

(2) the unique health identifier is the social security number of the patient;

(3) there is no federal alternate numbering system for patients who do not have or refuse to provide their social security numbers; and

(4) federal law or the federal Secretary of Health and Human Services explicitly allows a state to develop an alternate numbering system for patients who do not have or refuse to provide their social security numbers.

(f) If an alternate numbering system is developed under paragraph (e), patients who use numbers issued by the alternate numbering system are not required to provide their social security numbers and group purchasers or providers may not demand the social security numbers of patients who provide numbers issued by the alternate numbering system. If an alternate numbering system is developed under paragraph (e), 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 identifier.

(g) The commissioner of health may contract with the federal Secretary of Health and Human Services or the Secretary's agent to implement this subdivision.

History: *1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26-28; 1997 c 228 s 2; 1Sp1997 c 5 s 16*

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: *1994 c 625 art 9 s 6; 1995 c 234 art 5 s 18*

62J.56 IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.

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

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

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

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

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

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

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

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

(5) ANSI ASC X12 276/277 health care claims status request/notification transaction set.

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

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

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

claim task force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

History: *1994 c 625 art 9 s 7; 1996 c 440 art 1 s 29*

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

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

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

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

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

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

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

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

History: *1994 c 625 art 9 s 8*

62J.58 IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. **Claims payment.** 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/release 3051) 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/release 3051) for the electronic transfer of health care claim information.

Subd. 2a. **Claim status information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets under section 62J.56, subdivision 3, all category I and II industry participants, excluding pharmacists, may accept or submit the ANSI ASC X12 276/277 health care claim status transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim status 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/release 3051) 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/release 3051) 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: *1994 c 625 art 9 s 9; 1995 c 234 art 5 s 19; 1996 c 440 art 1 s 30*

62J.581 STANDARDS FOR MINNESOTA UNIFORM HEALTH CARE REIMBURSEMENT DOCUMENTS.

Subdivision 1. **Minnesota uniform remittance advice report.** (a) All group purchasers shall provide a uniform remittance advice report to health care providers when a claim is adjudicated. The uniform remittance advice report shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 2. **Minnesota uniform explanation of benefits document.** (a) All group purchasers shall provide a uniform explanation of benefits document to health care patients when an explanation of benefits document is provided as otherwise required or permitted by law. The uniform explanation of benefits document shall comply with the standards prescribed in this section.

(b) Notwithstanding paragraph (a), this section does not apply to group purchasers not included as covered entities under United States Code, title 42, sections 1320d to 1320d-8, as amended from time to time, and the regulations promulgated under those sections.

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the uniform remittance advice report and the uniform explanation of benefits document format specified in subdivision 4 shall apply to all health care services delivered by a health care provider or health care provider organization in Minnesota, regardless of the location of the payer. Health care services not paid on an individual claims basis, such as capitated payments, are not included in this section. A health plan company is excluded from the requirements in subdivisions 1 and 2 if they comply with section 62A.01, subdivisions 2 and 3.

Subd. 4. **Specifications.** The uniform remittance advice report and the uniform explanation of benefits document shall be provided by use of a paper document conforming to the specifications in this section or by use of the ANSI X12N 835 standard electronic format as established under United States Code, title 42, sections 1320d to 1320d-8, and as amended from time to time for the remittance advice. The commissioner, after consulting with the administrative uniformity committee, shall specify the data elements and definitions for the uniform remittance advice report and the uniform explanation of benefits document. The commissioner and the administrative uniformity committee must consult with the Minnesota Dental Association and Delta Dental Plan of Minnesota before requiring under this section the use of a paper document for the uniform explanation of benefits document or the uniform remittance advice report for dental care services.

Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective October 16, 2004. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

History: *2000 c 460 s 7; 2002 c 307 art 2 s 7; 2002 c 330 s 23*

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

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

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

History: *1994 c 625 art 9 s 10*

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

Subdivision 1. **Minnesota uniform health care identification card.** All individuals with health care coverage shall be issued Minnesota uniform health care identification cards by group purchasers as of January 1, 1998, unless the requirements of section 62A.01, subdivisions 2 and 3, are met. If a health benefit plan issued by a group purchaser provides coverage for prescription drugs, the group purchaser shall include uniform prescription drug information on the uniform health care identification card issued to its enrollees on or after July 1, 2003. Nothing in this section requires a group purchaser to issue a separate card containing uniform prescription drug information, provided that the Minnesota uniform health care identification card can accommodate the information necessary to process prescription drug claims as required by this section. The Minnesota uniform health care identification cards shall comply with the standards prescribed in this section.

Subd. 1a. **Definition; health benefit plan.** For purposes of this section, "health benefit plan" means a policy, contract, or certificate offered, sold, issued, or renewed by a group purchaser for the coverage of medical and hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile or homeowners medical payment coverage;

(3) liability insurance or supplemental to liability insurance;

(4) accident-only coverage;

(5) credit accident and health insurance issued under chapter 62B;

(6) designed solely to provide dental or vision care;

(7) designed solely to provide coverage for a specified disease or illness;

(8) coverage under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance; or

(9) hospital income or indemnity.

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent

pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

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

(c) Standardized labels are required next to human readable data elements and must come before the human readable data elements.

Subd. 2a. **Issuance.** A new Minnesota uniform health care identification card must be issued to individuals upon enrollment. Except for the medical assistance, general assistance medical care, and MinnesotaCare programs, a new card must be issued upon any change in an individual's health care coverage that impacts the content or format of the data included on the card or no later than 24 months after adoption of any change in the NCPDP implementation guide or successor document that affects the content or format of the data included on the card. Anytime that a card is issued upon enrollment or replaced by the medical assistance, general assistance medical care, or MinnesotaCare program, the card must conform to the adopted NCPDP standards in effect and to the implementation guide in use at the time of issuance. Newly issued cards must conform to the adopted NCPDP standards in effect at the time of issuance and to the implementation guide in use at the time of issuance. Stickers or other methodologies may be used to update cards temporarily.

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

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be "Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

(3) card issuer identification number. The standardized label for this element is "Issuer";

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

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

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

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

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

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

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

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

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

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

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

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

Subd. 5. **Annual reporting.** As part of an annual filing made with the commissioner of health or commerce on or after January 1, 2003, a group purchaser shall certify compliance with this section and shall submit to the commissioner of health or commerce a copy of the Minnesota uniform health care identification card used by the group purchaser.

History: *1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32; 1997 c 205 s 17; 1997 c 225 art 2 s 62; 2000 c 460 s 8; 2001 c 110 s 1*

62J.61 RULEMAKING; IMPLEMENTATION.

Subdivision 1. **Exemption.** The commissioner of health is exempt from chapter 14, including section 14.386, in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59.

Subd. 2. **Procedure.** (a) The commissioner shall publish proposed rules in the State Register or, if the commissioner determines that publishing the text of the proposed rules would be unduly cumbersome, shall publish notice of the proposed rules that contains a detailed description of the rules along with a statement that a free copy of the entire set of rules is available upon request to the agency.

(b) Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish notice in the State Register that the rules have been adopted 30 days before they are to take effect.

(c) If the adopted rules are the same as the proposed rules, the notice shall state that the rules have been adopted as proposed and shall cite the prior publication. If the adopted rules differ from the proposed rules, the portions of the adopted rules which differ from the proposed rules shall be included in the notice of adoption together with a citation to the prior State Register that contained the notice of the proposed rules.

(d) The commissioner may use rulemaking to implement sections 62J.54, subdivision 4, 62J.55, and 62J.60.

Subd. 3. **Restrictions.** The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically provided in this chapter.

Subd. 4. **Patient privacy.** The commissioner shall seek comments from the ethics and confidentiality committee of the Minnesota health data institute and the department of administration, public information policy analysis division, before adopting or publishing final rules relating to issues of patient privacy and medical records.

Subd. 5. **Biennial review of rulemaking procedures and rules.** The commissioner shall biennially seek comments from affected parties about the effectiveness of and continued need for the rulemaking procedures set out in subdivision 2 and about the quality and effectiveness of rules adopted using these procedures. The commissioner shall seek comments by holding a meeting and by publishing a notice in the State Register that contains the date, time, and location of the meeting and a statement that invites oral or written comments. The notice must be published at least 30 days before the meeting date. The commissioner shall write a report summarizing the comments and shall submit the report to the Minnesota health data institute and to the Minnesota administrative uniformity committee by January 15 of every even-numbered year.

History: *1994 c 625 art 9 s 12; 1997 c 187 art 4 s 3; 1998 c 254 art 1 s 14*

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 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 256L.09; 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*

62J.685 [Repealed, 1998 c 407 art 2 s 109]

62J.69 [Repealed, 1999 c 245 art 2 s 45]

MEDICAL EDUCATION AND RESEARCH

62J.691 PURPOSE.

The legislature finds that medical education and research are important to the health and economic well being of Minnesotans. The legislature further finds that, as a result of competition in the health care marketplace, these teaching and research institutions are facing increased difficulty funding medical education and research. The purpose of sections 62J.692 and 62J.693 is to help offset lost patient care revenue for those teaching institutions affected by increased competition in the health care marketplace and to help ensure the continued excellence of health care research in Minnesota.

History: *1999 c 245 art 2 s 9*

62J.692 MEDICAL EDUCATION.

Subdivision 1. **Definitions.** For purposes of this section, the following definitions apply:

(a) "Accredited clinical training" means the clinical training provided by a medical education program that is accredited through an organization recognized by the department of education, the Centers for Medicare and Medicaid Services, or another national body who reviews the accrediting organizations for multiple disciplines and whose standards for recognizing accrediting organizations are reviewed and approved by the commissioner of health in consultation with the medical education and research advisory committee.

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

(c) "Clinical medical education program" means the accredited clinical training of physicians (medical students and residents), doctor of pharmacy practitioners, doctors of chiropractic, dentists, advanced practice nurses (clinical nurse specialists, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(d) "Sponsoring institution" means a hospital, school, or consortium located in Minnesota that sponsors and maintains primary organizational and financial responsibility for a clinical medical education program in Minnesota and which is accountable to the accrediting body.

(e) "Teaching institution" means a hospital, medical center, clinic, or other organization that conducts a clinical medical education program in Minnesota.

(f) "Trainee" means a student or resident involved in a clinical medical education program.

(g) "Eligible trainee FTEs" means the number of trainees, as measured by full-time equivalent counts, that are at training sites located in Minnesota with a medical assistance provider number where training occurs in either an inpatient or ambulatory patient care setting and where the training is funded, in part, by patient care revenues.

Subd. 2. **Medical education and research advisory committee.** The commissioner shall appoint an advisory committee to provide advice and oversight on the distribution of funds appropriated for distribution under this section. In appointing the members, the commissioner shall:

(1) consider the interest of all stakeholders;

(2) appoint members that represent both urban and rural interests; and

(3) appoint members that represent ambulatory care as well as inpatient perspectives.

The commissioner shall appoint to the advisory committee representatives of the following groups to ensure appropriate representation of all eligible provider groups and other stakeholders: public and private medical researchers; public and private academic medical centers, including representatives from academic centers offering accredited training programs for physicians, pharmacists, chiropractors, dentists, nurses, and physician assistants; managed care organizations; employers; consumers and other relevant stakeholders. The advisory committee is governed by section 15.059.

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution is eligible for funds under subdivision 4 if the program:

(1) is funded, in part, by patient care revenues;

(2) occurs in patient care settings that face increased financial pressure as a result of competition with nonteaching patient care entities; and

(3) emphasizes primary care or specialties that are in undersupply in Minnesota.

(b) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received

by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

(1) the official name and address of the sponsoring institution and the official name and site address of the clinical medical education programs on whose behalf the sponsoring institution is applying;

(2) the name, title, and business address of those persons responsible for administering the funds;

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site; and

(4) other supporting information the commissioner deems necessary to determine program eligibility based on the criteria in paragraph (a) and to ensure the equitable distribution of funds.

(c) An application must include the information specified in clauses (1) to (3) for each clinical medical education program on an annual basis for three consecutive years. After that time, an application must include the information specified in clauses (1) to (3) in the first year of each biennium:

(1) audited clinical training costs per trainee for each clinical medical education program when available or estimates of clinical training costs based on audited financial data;

(2) a description of current sources of funding for clinical medical education costs, including a description and dollar amount of all state and federal financial support, including Medicare direct and indirect payments; and

(3) other revenue received for the purposes of clinical training.

(d) An applicant that does not provide information requested by the commissioner shall not be eligible for funds for the current funding cycle.

Subd. 4. **Distribution of funds.** (a) The commissioner shall annually distribute medical education funds to all qualifying applicants based on the following criteria:

(1) total medical education funds available for distribution;

(2) total number of eligible trainee FTEs in each clinical medical education program; and

(3) the statewide average cost per trainee as determined by the application information provided in the first year of the biennium, by type of trainee, in each clinical medical education program.

(b) Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(c) Funds shall be distributed to the sponsoring institutions indicating the amount to be distributed to each of the sponsor's clinical medical education programs based on the criteria in this subdivision and in accordance with the commissioner's approval letter. Each clinical medical education program must distribute funds to the training sites as specified in the commissioner's approval letter. Sponsoring institutions, which are accredited through an organization recognized by the department of education or the Centers for Medicare and Medicaid Services, may contract directly with training sites to provide clinical training. To ensure the quality of clinical training, those accredited sponsoring institutions must:

(1) develop contracts specifying the terms, expectations, and outcomes of the clinical training conducted at sites; and

(2) take necessary action if the contract requirements are not met. Action may include the withholding of payments under this section or the removal of students from the site.

(d) Any funds not distributed in accordance with the commissioner's approval letter must be returned to the medical education and research fund within 30 days of

receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(e) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under section 62J.694, subdivision 2a, paragraph (b), plus five percent interest to the University of Minnesota board of regents for the costs of the academic health center as specified under section 62J.694, subdivision 2a, paragraph (a).

Subd. 5. **Report.** (a) Sponsoring institutions receiving funds under this section must sign and submit a medical education grant verification report (GVR) to verify that the correct grant amount was forwarded to each eligible training site. If the sponsoring institution fails to submit the GVR by the stated deadline, or to request and meet the deadline for an extension, the sponsoring institution is required to return the full amount of funds received to the commissioner within 30 days of receiving notice from the commissioner. The commissioner shall distribute returned funds to the appropriate training sites in accordance with the commissioner's approval letter.

(b) The reports must provide verification of the distribution of the funds and must include:

(1) the total number of eligible trainee FTEs in each clinical medical education program;

(2) the name of each funded program and, for each program, the dollar amount distributed to each training site;

(3) documentation of any discrepancies between the initial grant distribution notice included in the commissioner's approval letter and the actual distribution;

(4) a statement by the sponsoring institution stating that the completed grant verification report is valid and accurate; and

(5) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for medical education.

(c) By February 15 of each year, the commissioner, with advice from the advisory committee, shall provide an annual summary report to the legislature on the implementation of this section.

Subd. 6. **Other available funds.** The commissioner is authorized to distribute, in accordance with subdivision 4, funds made available through:

(1) voluntary contributions by employers or other entities;

(2) allocations for the commissioner of human services to support medical education and research; and

(3) other sources as identified and deemed appropriate by the legislature for inclusion in the fund.

Subd. 7. **Transfers from the commissioner of human services.** (a) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (1), shall be distributed by the commissioner to clinical medical education programs that meet the qualifications of subdivision 3 based on a distribution formula that reflects a summation of two factors:

(1) an education factor, which is determined by the total number of eligible trainee FTEs and the total statewide average costs per trainee, by type of trainee, in each clinical medical education program; and

(2) a public program volume factor, which is determined by the total volume of public program revenue received by each training site as a percentage of all public program revenue received by all training sites in the fund pool created under this subdivision.

In this formula, the education factor shall be weighted at 50 percent and the public program volume factor shall be weighted at 50 percent.

Public program revenue for the distribution formula shall include revenue from medical assistance, prepaid medical assistance, general assistance medical care, and prepaid general assistance medical care. Training sites that receive no public program revenue shall be ineligible for funds available under this paragraph.

(b) Fifty percent of the amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40. Of the remaining amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (2), 24 percent of the amount shall be distributed by the commissioner to the Hennepin County Medical Center for clinical medical education. The remaining 26 percent of the amount transferred shall be distributed by the commissioner in accordance with subdivision 7a. If the federal approval is not obtained for the matching funds under section 256B.69, subdivision 5c, paragraph (a), clause (2), 100 percent of the amount transferred under this paragraph shall be distributed by the commissioner to the University of Minnesota board of regents for the purposes described in sections 137.38 to 137.40.

(c) The amount transferred according to section 256B.69, subdivision 5c, paragraph (a), clause (3), shall be distributed by the commissioner upon receipt to the University of Minnesota board of regents for the purposes of clinical graduate medical education.

Subd. 7a. **Clinical medical education innovations grants.** (a) The commissioner shall award grants to teaching institutions and clinical training sites for projects that increase dental access for underserved populations and promote innovative clinical training of dental professionals. In awarding the grants, the commissioner, in consultation with the commissioner of human services, shall consider the following:

(1) potential to successfully increase access to an underserved population;

(2) the long-term viability of the project to improve access beyond the period of initial funding;

(3) evidence of collaboration between the applicant and local communities;

(4) the efficiency in the use of the funding; and

(5) the priority level of the project in relation to state clinical education, access, and workforce goals.

(b) The commissioner shall periodically evaluate the priorities in awarding the innovations grants in order to ensure that the priorities meet the changing workforce needs of the state.

Subd. 8. **Federal financial participation.** The commissioner of human services shall seek to maximize federal financial participation in payments for medical education and research costs. If the commissioner of human services determines that federal financial participation is available for the medical education and research, the commissioner of health shall transfer to the commissioner of human services the amount of state funds necessary to maximize the federal funds available. The amount transferred to the commissioner of human services, plus the amount of federal financial participation, shall be distributed to medical assistance providers in accordance with the distribution methodology described in subdivision 4.

Subd. 9. **Review of eligible providers.** The commissioner and the medical education and research costs advisory committee may review provider groups included in the definition of a clinical medical education program to assure that the distribution of the funds continue to be consistent with the purpose of this section. The results of any such reviews must be reported to the legislative commission on health care access.

History: *1999 c 245 art 2 s 10; 2000 c 494 s 1-3; 2001 c 161 s 14; 1Sp2001 c 9 art 2 s 2,3; 2002 c 220 art 15 s 1,2; 2002 c 277 s 32; 2002 c 375 art 3 s 1; 2002 c 379 art 1 s 113*

62J.693 MEDICAL RESEARCH.

Subdivision 1. **Definitions.** For purposes of this section, health care research means approved clinical, outcomes, and health services investigations.

Subd. 2. **Grant application process.** (a) The commissioner of health shall make recommendations for a process for the submission, review, and approval of research grant applications. The process shall give priority for grants to applications that are intended to gather preliminary data for submission for a subsequent proposal for funding from a federal agency or foundation, which awards research money on a competitive, peer-reviewed basis. Grant recipients must be able to demonstrate the ability to comply with federal regulations on human subjects research in accordance with Code of Federal Regulations, title 45, section 46, and shall conduct the proposed research. Grants may be awarded to the University of Minnesota, the Mayo clinic, or any other public or private organization in the state involved in medical research. The commissioner shall report to the legislature by January 15, 2000, with recommendations.

(b) The commissioner may consult with the medical education and research advisory committee established in section 62J.692 in developing these recommendations or may appoint a research advisory committee to provide advice and oversight on the grant application process. If the commissioner appoints a research advisory committee, the committee shall be governed by section 15.059 for membership terms and removal of members.

History: *1999 c 245 art 2 s 11*

MEDICAL EDUCATION ENDOWMENT FUND

62J.694 MEDICAL EDUCATION ENDOWMENT FUND.

Subdivision 1. **Creation; use of cash reserves.** (a) The medical education endowment fund is created in the state treasury. The state board of investment shall invest the fund under section 11A.24. All earnings of the fund must be credited to the fund. The principal of the fund must be maintained inviolate, except that the principal may be used to make expenditures from the fund for the purposes specified in this section when the market value of the fund falls below 105 percent of the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2. For purposes of this section, "principal" means an amount equal to the cumulative total of the tobacco settlement payments received by the state and credited to the tobacco settlement fund under section 16A.87, subdivision 2.

(b) If the commissioner of finance determines that probable receipts to the general fund will be sufficient to meet the need for expenditures from the general fund for a fiscal biennium, after using the cash reserves of the tobacco use prevention and local public health endowment fund, excluding an amount sufficient to meet the annual appropriations in section 144.395, subdivision 2, the commissioner may use cash reserves of the medical education endowment fund, excluding the amounts needed to meet the appropriations described in subdivisions 2 and 2a, to pay expenses of the general fund. If cash reserves are transferred to the general fund to meet cash flow needs, the amount transferred, plus interest at a rate comparable to the rate earned by the state on invested treasurer's cash, as determined monthly by the commissioner, must be returned to the endowment fund as soon as sufficient cash balances are available in the general fund, but in any event before the end of the fiscal biennium. An amount necessary to pay the interest is appropriated from the general fund. If cash reserves of the endowment fund are used to pay expenses for the general fund, notwithstanding subdivision 2, paragraph (d), the academic health center shall be held harmless to the extent possible. When determining the fair market value of the fund, for the purposes described in subdivisions 2 and 2a, the value of the cash reserves transferred to the general fund must be included in the determination.

(c) The academic health center account is created as a separate account in the medical education endowment fund. The account is invested under paragraph (a). All earnings of the account must be credited to the account. The principal of the account must be maintained inviolate, except that the principal may be used to make expendi-

tures from the account for the purposes specified in subdivision 2a when the value of the account falls below an amount equal to deposits made to the account under section 16A.87, subdivision 3, paragraph (b).

Subd. 2. **Expenditures.** (a) Up to five percent of the fair market value of the fund excluding the value of the academic health center account, is annually appropriated for medical education activities in the state of Minnesota. The appropriations are to be transferred quarterly for the purposes identified in the following paragraphs.

(b) For fiscal year 2000, 70 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 30 percent of the appropriation is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(c) For fiscal year 2001, 49 percent of the appropriation in paragraph (a) is for transfer to the board of regents for the instructional costs of health professional programs at the academic health center and affiliated teaching institutions, and 51 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(d) For fiscal year 2002, and each year thereafter, 42 percent of the appropriation in paragraph (a) is appropriated for the instructional costs of health professional programs at the University of Minnesota academic health center, and 58 percent is for transfer to the commissioner of health to be distributed for medical education under section 62J.692.

(e) A maximum of $150,000 of each annual appropriation to the commissioner of health in paragraph (d) may be used by the commissioner for administrative expenses associated with implementing section 62J.692.

Subd. 2a. **Expenditure; academic health center account.** (a) Beginning in January 2002, up to five percent of the fair market value of the academic health center account is annually appropriated to the board of regents for the costs of the academic health center. Appropriations are to be transferred quarterly and may only be used for instructional costs of health professional programs at the academic health center and for interdisciplinary academic initiatives within the academic health center, except as specified in paragraph (b).

(b) Of the amount appropriated under paragraph (a), $4,850,000 shall be transferred annually to the commissioner of health no later than April 15 of each year for distribution under section 62J.692, subdivision 4.

Subd. 3. **Audits required.** The legislative auditor shall audit endowment fund expenditures to ensure that the money is spent for the purposes set out in this section.

Subd. 4. **Sunset.** The medical education endowment fund expires June 30, 2015. Upon expiration, the commissioner of finance shall transfer the principal and any remaining interest to the general fund.

History: *1999 c 245 art 11 s 2; 2000 c 392 s 3,4; 1Sp2001 c 1 art 2 s 3-5; 2002 c 220 art 15 s 3; 2002 c 374 art 8 s 1*

NOTE: The amendment to subdivision 1 by Laws 2002, chapter 374, article 8, section 1, is effective July 1, 2003. Laws 2002, chapter 374, article 8, section 8.

PATIENT PROTECTION ACT

62J.695 CITATION.

Sections 62J.695 to 62J.76 may be cited as the "Patient Protection Act."

History: *1997 c 237 s 1*

62J.70 DEFINITIONS.

Subdivision 1. **Applicability.** For purposes of sections 62J.70 to 62J.76, the terms defined in this section have the meanings given them.

Subd. 2. **Health care provider or provider.** "Health care provider" or "provider" means:

(1) a physician, nurse, or other provider as defined under section 62J.03;

(2) a hospital as defined under section 144.696, subdivision 3;

(3) an individual or entity that provides health care services under the medical assistance, general assistance medical care, MinnesotaCare, or state employee group insurance program; and

(4) an association, partnership, corporation, limited liability corporation, or other organization of persons or entities described in clause (1) or (2) organized for the purposes of providing, arranging, or administering health care services or treatment.

This section does not apply to trade associations, membership associations of health care professionals, or other organizations that do not directly provide, arrange, or administer health care services or treatment.

Subd. 3. **Health plan company.** "Health plan company" means health plan company as defined in section 62Q.01, subdivision 4.

Subd. 4. **Enrollee.** "Enrollee" means an individual covered by a health plan company or health insurance or health coverage plan and includes an insured policyholder, subscriber, contract holder, member, covered person, or certificate holder.

History: *1997 c 237 s 2*

62J.701 GOVERNMENTAL PROGRAMS.

Beginning January 1, 1999, the provisions in paragraphs (a) to (d) apply.

(a) For purposes of sections 62J.695 to 62J.80, the requirements and other provisions that apply to health plan companies also apply to governmental programs.

(b) For purposes of this section, "governmental programs" means the medical assistance program, the MinnesotaCare program, the general assistance medical care program, the state employee group insurance program, the public employees insurance program under section 43A.316, and coverage provided by political subdivisions under section 471.617.

(c) Notwithstanding paragraph (a), section 62J.72 does not apply to the fee-for-service programs under medical assistance, MinnesotaCare, and general assistance medical care.

(d) If a state commissioner or local unit of government contracts with a health plan company or a third-party administrator, the contract may assign any obligations under paragraph (a) to the health plan company or third-party administrator. Nothing in this paragraph shall be construed to remove or diminish any enforcement responsibilities of the commissioners of health or commerce provided in sections 62J.695 to 62J.80.

History: *1998 c 407 art 2 s 9*

62J.71 PROHIBITED PROVIDER CONTRACTS.

Subdivision 1. **Prohibited agreements and directives.** The following types of agreements and directives are contrary to state public policy, are prohibited under this section, and are null and void:

(1) any agreement or directive that prohibits a health care provider from communicating with an enrollee with respect to the enrollee's health status, health care, or treatment options, if the health care provider is acting in good faith and within the provider's scope of practice as defined by law;

(2) any agreement or directive that prohibits a health care provider from making a recommendation regarding the suitability or desirability of a health plan company, health insurer, or health coverage plan for an enrollee, unless the provider has a financial conflict of interest in the enrollee's choice of health plan company, health insurer, or health coverage plan;

(3) any agreement or directive that prohibits a provider from providing testimony, supporting or opposing legislation, or making any other contact with state or federal legislators or legislative staff or with state and federal executive branch officers or staff;

(4) any agreement or directive that prohibits a health care provider from disclosing accurate information about whether services or treatment will be paid for by a patient's health plan company or health insurer or health coverage plan; and

(5) any agreement or directive that prohibits a health care provider from informing an enrollee about the nature of the reimbursement methodology used by an enrollee's health plan company, health insurer, or health coverage plan to pay the provider.

Subd. 2. **Persons and entities affected.** The following persons and entities shall not enter into any agreement or directive that is prohibited under this section:

(1) a health plan company;

(2) a health care network cooperative as defined under section 62R.04, subdivision 3; or

(3) a health care provider as defined in section 62J.70, subdivision 2.

Subd. 3. **Retaliation prohibited.** No person, health plan company, or other organization may take retaliatory action against a health care provider solely on the grounds that the provider:

(1) refused to enter into an agreement or provide services or information in a manner that is prohibited under this section or took any of the actions listed in subdivision 1;

(2) disclosed accurate information about whether a health care service or treatment is covered by an enrollee's health plan company, health insurer, or health coverage plan;

(3) discussed diagnostic, treatment, or referral options that are not covered or are limited by the enrollee's health plan company, health insurer, or health coverage plan;

(4) criticized coverage of the enrollee's health plan company, health insurer, or health coverage plan; or

(5) expressed personal disagreement with a decision made by a person, organization, or health care provider regarding treatment or coverage provided to a patient of the provider, or assisted or advocated for the patient in seeking reconsideration of such a decision, provided the health care provider makes it clear that the provider is acting in a personal capacity and not as a representative of or on behalf of the entity that made the decision.

Subd. 4. **Exclusion.** (a) Nothing in this section prohibits an entity that is subject to this section from taking action against a provider if the entity has evidence that the provider's actions are illegal, constitute medical malpractice, or are contrary to accepted medical practices.

(b) Nothing in this section prohibits a contract provision or directive that requires any contracting party to keep confidential or to not use or disclose the specific amounts paid to a provider, provider fee schedules, provider salaries, and other proprietary information of a specific entity that is subject to this section.

History: *1997 c 237 s 3; 1998 c 407 art 2 s 10-12*

62J.72 DISCLOSURE OF HEALTH CARE PROVIDER INFORMATION.

Subdivision 1. **Written disclosure.** (a) A health plan company, as defined under section 62J.70, subdivision 3, a health care network cooperative as defined under section 62R.04, subdivision 3, and a health care provider as defined under section 62J.70, subdivision 2, shall, during open enrollment, upon enrollment, and annually thereafter, provide enrollees with a description of the general nature of the reimbursement methodologies used by the health plan company, health insurer, or health coverage plan to pay providers. The description must explain clearly any aspect of the reimbursement methodology that creates a financial incentive for the health care provider to limit or restrict the health care provided to enrollees. An entity required to disclose shall also disclose if no reimbursement methodology is used that creates a

financial incentive for the health care provider to limit or restrict the health care provided to enrollees. This description may be incorporated into the member handbook, subscriber contract, certificate of coverage, or other written enrollee communication. The general reimbursement methodology shall be made available to employers at the time of open enrollment.

(b) Health plan companies, health care network cooperatives, and providers must, upon request, provide an enrollee with specific information regarding the reimbursement methodology, including, but not limited to, the following information:

(1) a concise written description of the provider payment plan, including any incentive plan applicable to the enrollee;

(2) a written description of any incentive to the provider relating to the provision of health care services to enrollees, including any compensation arrangement that is dependent on the amount of health coverage or health care services provided to the enrollee, or the number of referrals to or utilization of specialists; and

(3) a written description of any incentive plan that involves the transfer of financial risk to the health care provider.

(c) The disclosure statement describing the general nature of the reimbursement methodologies must comply with the Readability of Insurance Policies Act in chapter 72C and must be filed with and approved by the commissioner prior to its use.

(d) A disclosure statement that has been filed with the commissioner for approval under paragraph (c) is deemed approved 30 days after the date of filing, unless approved or disapproved by the commissioner on or before the end of that 30-day period.

(e) The disclosure statement describing the general nature of the reimbursement methodologies must be provided upon request in English, Spanish, Vietnamese, and Hmong. In addition, reasonable efforts must be made to provide information contained in the disclosure statement to other non-English-speaking enrollees.

(f) Health plan companies and providers may enter into agreements to determine how to respond to enrollee requests received by either the provider or the health plan company. This subdivision does not require disclosure of specific amounts paid to a provider, provider fee schedules, provider salaries, or other proprietary information of a specific health plan company or health insurer or health coverage plan or provider.

Subd. 2. **Additional written disclosure of provider information.** In the event a health plan company prepares a written disclosure as specified in subdivision 1, in a manner that explicitly makes a comparison of the financial incentives between the providers with whom it contracts, it must describe the incentives that occur at the provider level.

Subd. 3. **Information on patients' medical bills.** A health plan company and health care provider shall provide patients and enrollees with a copy of an explicit and intelligible bill whenever the patient or enrollee is sent a bill and is responsible for paying any portion of that bill. The bills must contain descriptive language sufficient to be understood by the average patient or enrollee. This subdivision does not apply to a flat copay paid by the patient or enrollee at the time the service is required.

Subd. 4. **Nonapplicability.** Health care providers as defined in section 62J.70, subdivision 2, clause (1), need not individually provide information required under this section if it has been provided by another individual or entity that is subject to this section.

History: *1997 c 237 s 4; 1998 c 407 art 2 s 13*

62J.73 PROHIBITION ON EXCLUSIVE ARRANGEMENTS.

Subdivision 1. **Prohibition on exclusive relationships.** No provider, group of providers, or health plan company shall restrict a person's right to provide health services or procedures to another provider, group of providers, or health plan company, unless the person is an employee.

Subd. 2. **Prohibition on restrictive contract terms.** No provider, group of providers, or person providing goods or health services to a provider shall enter into a contract or subcontract with a health plan company or group of providers on terms that require the provider, group of providers, or person not to contract with another health plan company, unless the provider or person is an employee.

Subd. 3. **Prohibition regarding essential facilities and services.** (a) No health plan company, provider, or group of providers may withhold from its competitors health care services, which are essential for competition between health care providers within the meaning of the essential facilities doctrine as interpreted by the federal courts.

(b) This subdivision should be construed as an instruction to state court in interpreting federal law.

Subd. 4. **Violations.** Any provider or other individual who believes provisions of this section may have been violated may file a complaint with the attorney general's office regarding a possible violation of this section.

History: *1997 c 237 s 5*

62J.74 ENFORCEMENT.

Subdivision 1. **Authority.** The commissioners of health and commerce shall each periodically review contracts and arrangements among health care providing entities and health plan companies they regulate to determine compliance with sections 62J.70 to 62J.73. Any person may submit a contract or arrangement to the relevant commissioner for review if the person believes sections 62J.70 to 62J.73 have been violated. Any provision of a contract or arrangement found by the relevant commissioner to violate this section is null and void, and the relevant commissioner may assess civil penalties against the health plan company in an amount not to exceed $2,500 for each day the contract or arrangement is in effect, and may use the enforcement procedures otherwise available to the commissioner. All due process rights afforded under chapter 14 apply to this section.

Subd. 2. **Assistance to licensing boards.** A health-related licensing board as defined under section 214.01, subdivision 2, shall submit a contract or arrangement to the relevant commissioner for review if the board believes sections 62J.70 to 62J.73 have been violated. If the commissioner determines that any provision of a contract or arrangement violates those sections, the board may take disciplinary action against any person who is licensed or regulated by the board who entered into the contract arrangement.

History: *1997 c 237 s 6*

62J.75 [Expired]

62J.76 NONPREEMPTION.

Nothing in the Patient Protection Act preempts or replaces requirements related to patient protections that are more protective of patient rights than the requirements established by the Patient Protection Act.

History: *1997 c 237 s 8*

62J.77 [Repealed, 1999 c 245 art 2 s 45]

62J.78 [Repealed, 1999 c 245 art 2 s 45]

62J.79 [Repealed, 1999 c 245 art 2 s 45]

62J.80 RETALIATION.

A health plan company or health care provider shall not retaliate or take adverse action against an enrollee or patient who, in good faith, makes a complaint against a health plan company or health care provider. If retaliation is suspected, the executive director may report it to the appropriate regulatory authority.

History: *1998 c 407 art 2 s 18*