CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.052 PROVIDER COST DISCLOSURE.

(a) Each health care provider, as defined by section 62J.03, subdivision 8, except hospitals and outpatient surgical centers, shall provide the following information:

(1) the average allowable payment from private third-party payers for the 20 services or procedures most commonly performed;

(2) the average payment rates for those services and procedures for medical assistance;

(3) the average charge for those services and procedures for individuals who have no applicable private or public coverage; and

(4) the average charge for those services and procedures, including all patients.

(b) This information shall be updated annually and be readily available at no cost to the public on site.

History: *2005 c 147 art 11 s 2*

HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ADVISORY COMMITTEE

62J.495 HEALTH INFORMATION TECHNOLOGY AND INFRASTRUCTURE ADVISORY COMMITTEE.

Subdivision 1. **Establishment; members; duties.** (a) The commissioner shall establish a Health Information Technology and Infrastructure Advisory Committee governed by section 15.059 to advise the commissioner on the following matters:

(1) assessment of the use of health information technology by the state, licensed health care providers and facilities, and local public health agencies;

(2) recommendations for implementing a statewide interoperable health information infrastructure, to include estimates of necessary resources, and for determining standards for administrative data exchange, clinical support programs, patient privacy requirements, and maintenance of the security and confidentiality of individual patient data; and

(3) other related issues as requested by the commissioner.

(b) The members of the Health Information Technology and Infrastructure Advisory Committee shall include the commissioners, or commissioners' designees, of health, human services, administration, and commerce and additional members to be appointed by the commissioner to include persons representing Minnesota's local public health agencies, licensed hospitals and other licensed facilities and providers, private purchasers, the medical and nursing professions, health insurers and health plans, the state quality improvement organization, academic and research institutions, consumer advisory organizations with an interest and expertise in health information technology, and other stakeholders as identified by the Health Information Technology and Infrastructure Advisory Committee.

Subd. 2. **Annual report.** The commissioner shall prepare and issue an annual report not later than January 30 of each year outlining progress to date in implementing a statewide health information infrastructure and recommending future projects.

Subd. 3. **Expiration.** Notwithstanding section 15.059, this section expires June 30, 2009.

History: *1Sp2005 c 4 art 6 s 1*

62J.51 DEFINITIONS.

[For text of subds 1 to 16, see M.S.2004]

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

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the 1990 version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim Committee and any subsequent amendments to the form.

[For text of subds 19 to 21, see M.S.2004]

History: *2005 c 106 s 1,2*

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

Subdivision 1. **Uniform billing form CMS 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 CMS 1450, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 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 CMS 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, 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 CMS 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 CMS 1500, except as provided in subdivision 5.

(b) The instructions and definitions for the use of the uniform billing form CMS 1500 shall be in accordance with the manual developed by the Administrative Unifor-

mity Committee entitled standards for the use of the CMS 1500 form, dated February 1994, as further defined by the commissioner.

(c) Services to be billed using the uniform billing form CMS 1500 include physician services and supplies, durable medical equipment, noninstitutional ambulance services, independent ancillary services including occupational therapy, physical therapy, speech therapy and audiology, home infusion therapy, 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.

[For text of subds 3 and 4, see M.S.2004]

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 CMS 1450 for community mental health center services and shall accept the CMS 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 CMS 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 CMS 1450 or the CMS 1500 form, as designated by the Department of Human Services.

History: *2005 c 106 s 3-5*

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 national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers and any health care provider organization that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use a national provider identifier to identify health care provider organizations in Minnesota, according to this section, 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 national provider identifier to identify health provider organizations no later than 36 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers 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 in Minnesota under this section.

(d) All health care provider organizations in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify health care provider organizations when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Health care provider organizations in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(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.

Subd. 2. **Unique identification number for individual health care providers.** (a) Not later than 24 months after the date on which a national provider identifier is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments), all group purchasers in Minnesota and any individual health care provider that meets the definition of a health care provider under United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall use the national provider identifier to identify an individual health care provider in Minnesota, according to this section, 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 the national provider identifier to identify an individual health care provider no later than 36 months after the date on which a national provider identifier for health care providers is made effective under United States Code, title 42, sections 1320d to 1320d-8 (1996 and subsequent amendments).

(c) The national provider identifier for health care providers 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) All individual health care providers in Minnesota that are eligible to obtain a national provider identifier according to United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder shall obtain a national provider identifier from the federal Secretary of Health and Human Services using the process prescribed by the Secretary.

(e) Only the national provider identifier shall be used to identify individual health care providers when submitting and receiving paper and electronic claims and remittance advice notices, and in conjunction with other data collection and reporting functions.

(f) Individual health care providers in Minnesota shall make available their national provider identifier to other health care providers when required to be included in the administrative transactions regulated by United States Code, title 42, sections 1320d to 1320d-8, as amended, and regulations adopted thereunder.

(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.

[For text of subds 3 and 4, see M.S.2004]

History: *2005 c 106 s 6,7*

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

[For text of subds 1 to 4, see M.S.2004]

Subd. 5. **Effective date.** The requirements in subdivisions 1 and 2 are effective June 30, 2007. The requirements in subdivisions 1 and 2 apply regardless of when the health care service was provided to the patient.

History: *2005 c 106 s 8*

62J.692 MEDICAL EDUCATION.

[For text of subds 1 and 2, see M.S.2004]

Subd. 3. **Application process.** (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants 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.

A clinical medical education program that trains pediatricians is requested to include in its program curriculum training in case management and medication management for children suffering from mental illness to be eligible for funds under subdivision 4.

(b) A clinical medical education program for advanced practice nursing is eligible for funds under subdivision 4 if the program meets the eligibility requirements in paragraph (a), clauses (1) to (3), and is sponsored by the University of Minnesota Academic Health Center, the Mayo Foundation, or institutions that are part of the Minnesota State Colleges and Universities system or members of the Minnesota Private College Council.

(c) 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 paragraphs (a) and (b) and to ensure the equitable distribution of funds.

(d) 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) when requested, at the discretion of the commissioner:

(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.

(e) 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 90 percent of available medical education funds to all qualifying applicants 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.

In this formula, the education factor is weighted at 67 percent and the public program volume factor is weighted at 33 percent.

Public program revenue for the distribution formula includes 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 are ineligible for funds available under this paragraph. Total statewide average costs per trainee for medical residents is based on audited clinical training costs per trainee in primary care clinical medical education programs for medical residents. Total statewide average costs per trainee for dental residents is based on audited clinical training costs per trainee in clinical medical education programs for dental students. Total statewide average costs per trainee for pharmacy residents is based on audited clinical training costs per trainee in clinical medical education programs for pharmacy students.

(b) The commissioner shall annually distribute ten percent of total available medical education funds to all qualifying applicants based on the percentage received by each applicant under paragraph (a). These funds are to be used to offset clinical education costs at eligible clinical training sites based on criteria developed by the clinical medical education program. Applicants may choose to distribute funds allocated under this paragraph based on the distribution formula described in paragraph (a).

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

(d) 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 allocated under paragraph (a) 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.

(e) 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.

(f) The commissioner shall distribute by June 30 of each year an amount equal to the funds transferred under subdivision 10, plus five percent interest to the University of Minnesota Board of Regents for the instructional costs of health professional programs at the Academic Health Center and for interdisciplinary academic initiatives within the Academic Health Center.

(g) A maximum of $150,000 of the funds dedicated to the commissioner under section 297F.10, subdivision 1, paragraph (b), clause (2), may be used by the commissioner for administrative expenses associated with implementing this section.

[For text of subds 5 and 6, see M.S.2004]

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 annually to clinical medical education programs that meet the qualifications of subdivision 3 based on the formula in subdivision 4, paragraph (a).

(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), clauses (3) and (4), shall be distributed by the commissioner upon receipt to the University of Minnesota Board of Regents for the purposes of clinical graduate medical education.

[For text of subds 7a to 10, see M.S.2004]

History: *2005 c 10 art 1 s 81; 2005 c 84 s 1-3; 1Sp2005 c 4 art 2 s 1*

62J.82 HOSPITAL CHARGE DISCLOSURE.

The Minnesota Hospital Association shall develop a Web-based system, available to the public free of charge, for reporting charge information, for Minnesota residents, including, but not limited to, number of discharges, average length of stay, average charge, average charge per day, and median charge, for each of the 50 most common inpatient diagnosis-related groups and the 25 most common outpatient surgical procedures as specified by the Minnesota Hospital Association. The Web site must provide information that compares hospital-specific data to hospital statewide data. The Web site must be established by October 1, 2006, and must be updated annually. If a hospital does not provide this information to the Minnesota Hospital Association, the commissioner may require the hospital to do so. The commissioner shall provide a link to this information on the department's Web site.

History: *1Sp2005 c 4 art 8 s 2*