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State of Minnesota

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HOUSE OF REPRESENTATIVES

EIGHTY-EIGHTH SESSION

H. F. No. 2874

03/10/2014 Authored by Liebling
The bill was read for the first time and referred to the Committee on Health and Human Services Policy
03/31/2014 Adoption of Report: Placed on the General Register
Read Second Time
04/09/2014 Calendar for the Day, Amended
Read Third Time as Amended
Passed by the House as Amended and transmitted to the Senate to include Floor Amendments

A bill for an act

relating to health; making technical changes; eliminating or modernizing antiquated, unnecessary, and obsolete provisions; amending Minnesota Statutes 2012, sections 62J.50, subdivisions 1, 2; 62J.51; 62J.52, as amended; 62J.53; 62J.535; 62J.536, subdivision 2; 62J.54, subdivisions 1, 2, 3; 62J.56, subdivisions 1, 2, 3; 62J.581, subdivisions 1, 3, 4; 62J.61, subdivision 1; 122A.40, subdivision 12; 122A.41, subdivision 6; 144.12, subdivision 1; 154.25; 626.557, subdivision 12b; repealing Minnesota Statutes 2012, sections 62J.322; 62J.59; 144.011, subdivision 2; 144.0506; 144.071; 144.072; 144.076; 144.146, subdivision 1; 144.1475; 144.443; 144.444; 144.45; 145.132; 145.97; 145.98, subdivisions 1, 3.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF MINNESOTA:

ARTICLE 1

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT

Section 1. Minnesota Statutes 2012, section 62J.50, subdivision 1, is amended to read:

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

Sec. 2. Minnesota Statutes 2012, section 62J.50, subdivision 2, is amended to read:

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, now known as the Centers for Medicare and Medicaid Services, 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.

Sec. 3. Minnesota Statutes 2012, section 62J.51, is amended to read:

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 as adopted under Code of Federal Regulations, title 45, part 162, subpart P, and any future revisions of the subpart.

Subd. 6a. **Claim status transaction set (ANSI ASC X12 276/277).** "Claim status transaction set (ANSI ASC X12 276/277)" means the electronic 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 as adopted under Code of Federal Regulations, title 45, part 162, subpart N, and any future revisions of the subpart.

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 as adopted under Code of Federal Regulations, title 45, part 162, subpart K, and any future revisions of the subpart.

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 electronic 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 as adopted under Code of Federal Regulations, title 45, part 162, subpart L, and any future revisions of the subpart.

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 as adopted under Code of Federal Regulations, title 45, part 162, subpart O, and any future revisions of the subpart.

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

Subd. 11a. **Health care clearinghouse.** "Health care clearinghouse" means a public or private entity, including a billing service, repricing company, community health management information system or community health information system, and "value-added" networks and switches that does any of the following functions:

(1) processes or facilitates the processing of health information received from another entity in a nonstandard format or containing nonstandard data content into standard data elements or a standard transaction;

(2) receives a standard transaction from another entity and processes or facilitates the processing of health information into nonstandard format or nonstandard data content for the receiving entity;

(3) acts on behalf of a group purchaser in sending and receiving standard transactions to assist the group purchaser in fulfilling its responsibilities under section 62J.536;

(4) acts on behalf of a health care provider in sending and receiving standard transactions to assist the health care provider in fulfilling its responsibilities under section 62J.536; and

(5) other activities including but not limited to training, testing, editing, formatting, or consolidation transactions.

A health care clearinghouse acts as an agent of a health care provider or group purchaser only if it enters into an explicit, mutually agreed upon arrangement or contract with the provider or group purchaser to perform specific clearinghouse functions.

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. 16a. **Standard transaction.** "Standard transaction" means a transaction that is defined in Code of Federal Regulations, title 45, part 162.103, and that meets the requirements of the single, uniform companion guides described in section 62J.536.

Subd. 17. **Uniform billing form CMS 1450.** "Uniform billing form CMS 1450" means the most current version of the uniform billing form known as the CMS 1450 developed by the National Uniform Billing Committee.

Subd. 18. **Uniform billing form CMS 1500.** "Uniform billing form CMS 1500" means the most current version of the health insurance claim form, CMS 1500, developed by the National Uniform Claim Committee.

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~~.

Sec. 4. Minnesota Statutes 2012, section 62J.52, as amended by Laws 2013, chapter 125, article 1, section 107, is amended to read:

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 most current version of 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.

(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, ICFs/DD, 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, federally qualified health centers, and community mental health centers; home health services such as home health intravenous therapy providers 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.

(e) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

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 most current version of 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 Uniformity 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, waivered services, personal care attendants, and other health care providers such as day activity centers and freestanding ambulatory surgical centers.

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

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 most current version of 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 most current version of the NCPDP/universal claim form.

(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.

Sec. 5. Minnesota Statutes 2012, section 62J.53, is amended to read:

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.

Sec. 6. Minnesota Statutes 2012, section 62J.535, is amended to read:

62J.535 UNIFORM BILLING REQUIREMENTS FOR CLAIM TRANSACTIONS.

Subd. 1a. ~~**Electronic claim transactions**~~ **Additional information associated with a claim.** ~~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.~~

Sec. 7. Minnesota Statutes 2012, section 62J.536, subdivision 2, is amended to read:

Subd. 2. **Establishing uniform, standard companion guides.** (a) At least 12 months prior to the timelines required in subdivision 1, the commissioner of health shall promulgate rules pursuant to section 62J.61 establishing and requiring group purchasers and health care providers to use the transactions and the uniform, standard companion guides required under subdivision 1, paragraph ~~(e)~~ (f).

(b) The commissioner of health must consult with the Minnesota Administrative Uniformity Committee on the development of the single, uniform companion guides required under subdivision 1, paragraph ~~(e)~~ (f), for each of the transactions in subdivision 1. The single uniform companion guides required under subdivision 1, paragraph ~~(e)~~ (f), must specify uniform billing and coding standards. The commissioner of health shall base the companion guides required under subdivision 1, paragraph ~~(e)~~ (f), billing and coding rules, and standards on the Medicare program, with modifications that the commissioner deems appropriate after consulting the Minnesota Administrative Uniformity Committee.

(c) No group purchaser or health care provider may add to or modify the single, uniform companion guides defined in subdivision 1, paragraph ~~(e)~~ (f), through additional companion guides or other requirements.

(d) In promulgating the rules in paragraph (a), the commissioner shall not require data content that is not essential to accomplish the purpose of the transactions in subdivision 1.

Sec. 8. Minnesota Statutes 2012, section 62J.54, subdivision 1, is amended to read:

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)~~ (b) 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),~~ as adopted and required in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart shall be used as the unique identification number for health care provider organizations in Minnesota under this section.

~~(d)~~ (c) 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~~ in Code of Federal Regulations, title 45, subpart D, and any future modifications to the subpart.

~~(e)~~ (d) 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)~~ (e) 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)~~ (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.

Sec. 9. Minnesota Statutes 2012, section 62J.54, subdivision 2, is amended to read:

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)~~ (b) 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),~~ adopted in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart shall be used as the unique identification number for individual health care providers.

~~(d)~~ (c) 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~~ in Code of Federal Regulations, title 45, part 162, subpart D, and any future modifications to the subpart.

~~(e)~~ (d) 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)~~ (e) 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)~~ (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.

Sec. 10. Minnesota Statutes 2012, section 62J.54, subdivision 3, is amended to read:

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)~~ (b) The unique health identifier for group purchasers that are 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~~ under Code of Federal Regulations, title 45, part 160, subpart A, shall be the Standard Unique Health Identifier for Health Plans as adopted in Code of Federal Regulations, title 45, part 162, subpart E, and any future modifications to the subpart, effective as required by the subpart.

~~(d)~~ (c) Group purchasers that are health plans under Code of Federal Regulations, title 45, part 160, subpart A, shall obtain a unique health identifier ~~from the federal Secretary of Health and Human Services~~ using the process prescribed ~~by the Secretary~~ in Code of Federal Regulations, title 45, part 162, subpart E, and any future modifications to the subpart.

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

Sec. 11. Minnesota Statutes 2012, section 62J.56, subdivision 1, is amended to read:

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.~~

Sec. 12. Minnesota Statutes 2012, section 62J.56, subdivision 2, is amended to read:

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.

Sec. 13. Minnesota Statutes 2012, section 62J.56, subdivision 3, is amended to read:

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 National Uniform Claim ~~Task Force~~ Committee; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

Sec. 14. Minnesota Statutes 2012, section 62J.581, subdivision 1, is amended to read:

Subdivision 1. **Minnesota uniform remittance advice ~~report.~~** ~~(a)~~ All group purchasers shall provide a uniform ~~remittance advice report~~ claim payment/advice transaction to health care providers when a claim is adjudicated. The uniform ~~remittance advice report~~ claim payment/advice transaction shall comply with ~~the standards prescribed in this~~ section 62J.536, subdivision 1b, and rules adopted under section 62J.536, subdivision 2.

~~(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.~~

Sec. 15. Minnesota Statutes 2012, section 62J.581, subdivision 3, is amended to read:

Subd. 3. **Scope.** For purposes of sections 62J.50 to 62J.61, the uniform ~~remittance advice report and the~~ claim payment/advice transaction and 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.

Sec. 16. Minnesota Statutes 2012, section 62J.581, subdivision 4, is amended to read:

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~~ claim payment/advice transaction for dental care services.

Sec. 17. Minnesota Statutes 2012, section 62J.61, subdivision 1, is amended to read:

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~~ 62J.581.

Sec. 18. **REVISOR'S INSTRUCTION.**

The revisor shall make changes necessary to correct punctuation, grammar, and structure of the remaining text required by the repealed section in this article.

Sec. 19. **REPEALER.**

Minnesota Statutes 2012, section 62J.59, is repealed.

ARTICLE 2

COMBINING REPORTS ON VULNERABLE ADULTS MALTREATMENT

Section 1. Minnesota Statutes 2012, section 626.557, subdivision 12b, is amended to read:

Subd. 12b. **Data management.** (a) In performing any of the duties of this section as a lead investigative agency, the county social service agency shall maintain appropriate records. Data collected by the county social service agency under this section are welfare data under section 13.46. Notwithstanding section 13.46, subdivision 1, paragraph (a), data under this paragraph that are inactive investigative data on an individual who is a

vendor of services are private data on individuals, as defined in section 13.02. The identity of the reporter may only be disclosed as provided in paragraph (c).

Data maintained by the common entry point are confidential data on individuals or protected nonpublic data as defined in section 13.02. Notwithstanding section 138.163, the common entry point shall maintain data for three calendar years after date of receipt and then destroy the data unless otherwise directed by federal requirements.

(b) The commissioners of health and human services shall prepare an investigation memorandum for each report alleging maltreatment investigated under this section. County social service agencies must maintain private data on individuals but are not required to prepare an investigation memorandum. During an investigation by the commissioner of health or the commissioner of human services, data collected under this section are confidential data on individuals or protected nonpublic data as defined in section 13.02. Upon completion of the investigation, the data are classified as provided in clauses (1) to (3) and paragraph (c).

(1) The investigation memorandum must contain the following data, which are public:

(i) the name of the facility investigated;

(ii) a statement of the nature of the alleged maltreatment;

(iii) pertinent information obtained from medical or other records reviewed;

(iv) the identity of the investigator;

(v) a summary of the investigation's findings;

(vi) statement of whether the report was found to be substantiated, inconclusive, false, or that no determination will be made;

(vii) a statement of any action taken by the facility;

(viii) a statement of any action taken by the lead investigative agency; and

(ix) when a lead investigative agency's determination has substantiated maltreatment, a statement of whether an individual, individuals, or a facility were responsible for the substantiated maltreatment, if known.

The investigation memorandum must be written in a manner which protects the identity of the reporter and of the vulnerable adult and may not contain the names or, to the extent possible, data on individuals or private data listed in clause (2).

(2) Data on individuals collected and maintained in the investigation memorandum are private data, including:

(i) the name of the vulnerable adult;

(ii) the identity of the individual alleged to be the perpetrator;

(iii) the identity of the individual substantiated as the perpetrator; and

(iv) the identity of all individuals interviewed as part of the investigation.

(3) Other data on individuals maintained as part of an investigation under this section are private data on individuals upon completion of the investigation.

(c) After the assessment or investigation is completed, the name of the reporter must be confidential. The subject of the report may compel disclosure of the name of the reporter only with the consent of the reporter or upon a written finding by a court that the report was false and there is evidence that the report was made in bad faith. This subdivision does not alter disclosure responsibilities or obligations under the Rules of Criminal Procedure, except that where the identity of the reporter is relevant to a criminal prosecution, the district court shall do an in-camera review prior to determining whether to order disclosure of the identity of the reporter.

(d) Notwithstanding section 138.163, data maintained under this section by the commissioners of health and human services must be maintained under the following schedule and then destroyed unless otherwise directed by federal requirements:

(1) data from reports determined to be false, maintained for three years after the finding was made;

(2) data from reports determined to be inconclusive, maintained for four years after the finding was made;

(3) data from reports determined to be substantiated, maintained for seven years after the finding was made; and

(4) data from reports which were not investigated by a lead investigative agency and for which there is no final disposition, maintained for three years from the date of the report.

(e) The commissioners of health and human services shall ~~each~~ annually ~~report to the legislature and the governor on~~ publish on their Web sites the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigation under this section, and the resolution of those investigations. ~~The report shall identify:~~ On a biennial basis, the commissioners of health and human services shall jointly report the following information to the legislature and the governor:

(1) the number and type of reports of alleged maltreatment involving licensed facilities reported under this section, the number of those requiring investigations under this section, the resolution of those investigations, and which of the two lead agencies was responsible;

(2) trends about types of substantiated maltreatment found in the reporting period;

(3) if there are upward trends for types of maltreatment substantiated, recommendations for addressing and responding to them;

(4) efforts undertaken or recommended to improve the protection of vulnerable adults;

(5) whether and where backlogs of cases result in a failure to conform with statutory time frames and recommendations for reducing backlogs if applicable;

~~(2) where adequate coverage requires additional appropriations and staffing; and~~

~~(3) any other trends that affect the safety of vulnerable adults.~~

(6) recommended changes to statutes affecting the protection of vulnerable adults; and

(7) any other information that is relevant to the report trends and findings.

(f) Each lead investigative agency must have a record retention policy.

(g) Lead investigative agencies, prosecuting authorities, and law enforcement agencies may exchange not public data, as defined in section 13.02, if the agency or authority requesting the data determines that the data are pertinent and necessary to the requesting agency in initiating, furthering, or completing an investigation under this section. Data collected under this section must be made available to prosecuting authorities and law enforcement officials, local county agencies, and licensing agencies investigating the alleged maltreatment under this section. The lead investigative agency shall exchange not public data with the vulnerable adult maltreatment review panel established in section 256.021 if the data are pertinent and necessary for a review requested under that section. Notwithstanding section 138.17, upon completion of the review, not public data received by the review panel must be destroyed.

(h) Each lead investigative agency shall keep records of the length of time it takes to complete its investigations.

(i) A lead investigative agency may notify other affected parties and their authorized representative if the lead investigative agency has reason to believe maltreatment has occurred and determines the information will safeguard the well-being of the affected parties or dispel widespread rumor or unrest in the affected facility.

(j) Under any notification provision of this section, where federal law specifically prohibits the disclosure of patient identifying information, a lead investigative agency may not provide any notice unless the vulnerable adult has consented to disclosure in a manner which conforms to federal requirements.

ARTICLE 3

TUBERCULOSIS

Section 1. Minnesota Statutes 2012, section 122A.40, subdivision 12, is amended to read:

Subd. 12. **Suspension and leave of absence for health reasons.** Affliction with ~~active tuberculosis or other~~ a communicable disease, mental illness, drug or alcoholic addiction, or other serious incapacity shall be grounds for temporary suspension and

leave of absence while the teacher is suffering from such disability. Unless the teacher consents, such action must be taken only upon evidence that suspension is required from a physician who has examined the teacher. The physician must be competent in the field involved and must be selected by the teacher from a list of three provided by the school board, and the examination must be at the expense of the school district. A copy of the report of the physician shall be furnished the teacher upon request. If the teacher fails to submit to the examination within the prescribed time, the board may discharge the teacher, effective immediately. In the event of mental illness, if the teacher submits to such an examination and the examining physician's or psychiatrist's statement is unacceptable to the teacher or the board, a panel of three physicians or psychiatrists must be selected to examine the teacher at the board's expense. The board and the teacher shall each select a member of this panel, and these two members shall select a third member. The panel must examine the teacher and submit a statement of its findings and conclusions to the board. Upon receipt and consideration of the statement from the panel the board may suspend the teacher. The board must notify the teacher in writing of such suspension and the reasons therefor. During the leave of absence, the district must pay the teacher sick leave benefits up to the amount of unused accumulated sick leave, and after it is exhausted, the district may in its discretion pay additional benefits. The teacher must be reinstated to the teacher's position upon evidence from such a physician of sufficient recovery to be capable of resuming performance of duties in a proper manner. In the event that the teacher does not qualify for reinstatement within 12 months after the date of suspension, the continuing disability may be a ground for discharge under subdivision 13.

Sec. 2. Minnesota Statutes 2012, section 122A.41, subdivision 6, is amended to read:

Subd. 6. **Grounds for discharge or demotion.** (a) Except as otherwise provided in paragraph (b), causes for the discharge or demotion of a teacher either during or after the probationary period must be:

(1) immoral character, conduct unbecoming a teacher, or insubordination;

(2) failure without justifiable cause to teach without first securing the written release of the school board having the care, management, or control of the school in which the teacher is employed;

(3) inefficiency in teaching or in the management of a school, consistent with subdivision 5, paragraph (b);

(4) affliction with ~~active tuberculosis or other~~ a communicable disease must be considered as cause for removal or suspension while the teacher is suffering from such disability; or

(5) discontinuance of position or lack of pupils.

For purposes of this paragraph, conduct unbecoming a teacher includes an unfair discriminatory practice described in section 363A.13.

(b) A probationary or continuing-contract teacher must be discharged immediately upon receipt of notice under section 122A.20, subdivision 1, paragraph (b), that the teacher's license has been revoked due to a conviction for child abuse or sexual abuse.

Sec. 3. Minnesota Statutes 2012, section 154.25, is amended to read:

154.25 NOT TO SERVE CERTAIN PERSONS.

No person practicing the occupation of a barber in any barber shop, barber school, or college in this state shall knowingly serve a person afflicted, in a dangerous or infectious state of the disease, with erysipelas, eczema, impetigo, sycosis, ~~tuberculosis,~~ or any other contagious or infectious disease. Any person so afflicted is hereby prohibited from being served in any barber shop, barber school, or college in this state. Any violation of this section shall be considered a misdemeanor as provided for in sections 154.001, 154.002, 154.003, 154.01 to 154.161, 154.19 to 154.21, and 154.24 to 154.26.

Sec. 4. **REVISOR'S INSTRUCTION.**

The revisor shall make changes necessary to correct punctuation, grammar, and structure of the remaining text required by the repealed sections in this article.

Sec. 5. **REPEALER.**

Minnesota Statutes 2012, sections 144.443; 144.444; and 144.45, are repealed.

ARTICLE 4

MISCELLANEOUS

Section 1. Minnesota Statutes 2012, section 144.12, subdivision 1, is amended to read:

Subdivision 1. **Rules.** The commissioner may adopt reasonable rules pursuant to chapter 14 for the preservation of the public health. The rules shall not conflict with the charter or ordinance of a city of the first class upon the same subject. The commissioner may control, by rule, by requiring the taking out of licenses or permits, or by other appropriate means, any of the following matters:

(1) the manufacture into articles of commerce, other than food, of diseased, tainted, or decayed animal or vegetable matter;

(2) the business of scavengering and the disposal of sewage;

(3) the location of mortuaries and cemeteries and the removal and burial of the dead;

(4) the management of boarding places for infants and the treatment of infants in them;

(5) the pollution of streams and other waters and the distribution of water by persons for drinking or domestic use;

(6) the construction and equipment, in respect to sanitary conditions, of schools, hospitals, almshouses, prisons, and other public institutions, and of lodging houses and other public sleeping places kept for gain;

(7) the treatment, in hospitals and elsewhere, of persons suffering from communicable diseases, including all manner of venereal disease and infection, the disinfection and quarantine of persons and places in case of those diseases, and the reporting of sicknesses and deaths from them;

Neither the commissioner nor any community health board ~~of health~~ as defined in section 145A.02, subdivision ~~2~~ 5, nor director of public health may adopt any rule or regulation for the treatment in any penal or correctional institution of any person suffering from any communicable disease or venereal disease or infection, which requires the involuntary detention of any person after the expiration of the period of sentence to the penal or correctional institution, or after the expiration of the period to which the sentence may be reduced by good time allowance or by the lawful order of any judge or the Department of Corrections;

(8) the prevention of infant blindness and infection of the eyes of the newly born by the designation, from time to time, of one or more prophylactics to be used in those cases and in the manner that the commissioner directs, unless specifically objected to by a parent of the infant;

~~(9) The furnishing of vaccine matter; the assembling, during epidemics of smallpox, with other persons not vaccinated, but no rule of the board or of any public board or officer shall at any time compel the vaccination of a child, or exclude, except during epidemics of smallpox and when approved by the local board of education, a child from the public schools for the reason that the child has not been vaccinated; any person required to be vaccinated may select for that purpose any licensed physician and no rule shall require the vaccination of any child whose physician certifies that by reason of the child's physical condition vaccination would be dangerous;~~

~~(10)~~ (9) the accumulation of filthy and unwholesome matter to the injury of the public health and its removal;

~~(11)~~ (10) the collection, recording, and reporting of vital statistics by public officers and the furnishing of information to them by physicians, undertakers, and others of births, deaths, causes of death, and other pertinent facts;

~~(12)~~ (11) the construction, equipment, and maintenance, in respect to sanitary conditions, of lumber camps, migratory or migrant labor camps, and other industrial camps;

~~(13)~~ (12) the general sanitation of tourist camps, summer hotels, and resorts in respect to water supplies, disposal of sewage, garbage, and other wastes and the prevention and control of communicable diseases; and, to that end, may prescribe the respective duties of agents of a board of health as authorized under section 145A.04; and all boards of health shall make such investigations and reports and obey such directions as the commissioner may require or give and, under the supervision of the commissioner, enforce the rules;

~~(14)~~ (13) atmospheric pollution which may be injurious or detrimental to public health;

~~(15)~~ (14) sources of radiation, and the handling, storage, transportation, use and disposal of radioactive isotopes and fissionable materials; and

~~(16)~~ (15) the establishment, operation and maintenance of all clinical laboratories not owned, or functioning as a component of a licensed hospital. These laboratories shall not include laboratories owned or operated by five or less licensed practitioners of the healing arts, unless otherwise provided by federal law or regulation, and in which these practitioners perform tests or procedures solely in connection with the treatment of their patients. Rules promulgated under the authority of this clause, which shall not take effect until federal legislation relating to the regulation and improvement of clinical laboratories has been enacted, may relate at least to minimum requirements for external and internal quality control, equipment, facility environment, personnel, administration and records. These rules may include the establishment of a fee schedule for clinical laboratory inspections. The provisions of this clause shall expire 30 days after the conclusion of any fiscal year in which the federal government pays for less than 45 percent of the cost of regulating clinical laboratories.

Sec. 2. **REVISOR'S INSTRUCTION.**

The revisor shall make changes necessary to correct punctuation, grammar, and structure of the remaining text required by the repealed sections in this article.

Sec. 3. **REPEALER.**

Minnesota Statutes 2012, sections 62J.322; 144.011, subdivision 2; 144.0506; 144.071; 144.072; 144.076; 144.146, subdivision 1; 144.1475; 145.132; 145.97; and 145.98, subdivisions 1 and 3, are repealed.

APPENDIX
Article locations in H2874-1

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.

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

(a) All category I and II pharmacies licensed in this state shall use the most recent HIPAA-mandated version of the NCPDP telecommunication standard or the NCPDP batch standard for the electronic submission of claims to group purchasers as appropriate.

(b) All category I and category II group purchasers in this state shall use the most recent HIPAA-mandated version of the NCPDP telecommunication standard or NCPDP batch standard for the electronic NCPDP response transaction to pharmacies as appropriate.

144.011 DEPARTMENT OF HEALTH.

Subd. 2. **State Health Advisory Task Force.** The commissioner of health may appoint a State Health Advisory Task Force. If appointed, members of the task force shall be broadly representative of the licensed health professions and shall also include public members as defined by section 214.02. The task force shall expire, and the terms, compensation, and removal of members shall be as provided in section 15.059.

144.0506 AGENCY WEB SITES.

Subdivision 1. **Information to be posted.** The commissioner of health may post the following information on agency Web sites, including minnesotahealthinfo.com:

(1) healthy lifestyle and preventive health care information, organized by sex and age, with procedures and treatments categorized by level of effectiveness and reliability of the supporting evidence on effectiveness;

(2) health plan company administrative efficiency report cards;

(3) health care provider charges for common procedures, based on information available under section 62J.052;

(4) evidence-based medicine guidelines and related information for use as resources by health care professionals, and summaries of the guidelines and related information for use by patients and consumers;

(5) resources and Web links related to improving efficiency in medical clinics and health care professional practices; and

(6) lists of nonprofit and charitable entities that accept donations of used medical equipment and supplies, such as crutches and walkers.

Subd. 2. **Other Internet resources.** The commissioner of health, in implementing subdivision 1, shall include relevant Web links and materials from private sector and other government sources in order to avoid duplication and reduce state administrative costs.

Subd. 3. **Cooperation with commissioner of commerce.** The commissioner of health shall consult and work in cooperation with the commissioner of commerce when posting on the Web site information collected from health plan companies regulated by the commissioner of commerce.

144.071 MERIT SYSTEM FOR LOCAL EMPLOYEES.

The commissioner may establish a merit system for employees of county or municipal health departments or public health nursing services or health districts, and may promulgate rules governing the administration and operation thereof. In the establishment and administration of the merit system authorized by this section, the commissioner may utilize facilities and personnel of any state department or agency with the consent of such department or agency. The commissioner may also, by rule, cooperate with the federal government in any manner necessary to qualify for federal aid.

144.072 IMPLEMENTATION OF SOCIAL SECURITY AMENDMENTS OF 1972.

Subdivision 1. **Rules.** The state commissioner of health shall implement by rule, pursuant to the Administrative Procedure Act, those provisions of the Social Security Amendments of 1972 (Public Law 92-603) required of state health agencies, including rules which:

(a) establish a plan, consistent with regulations prescribed by the secretary of health, education, and welfare, for the review by appropriate professional health personnel, of the appropriateness and quality of care and services furnished to recipients of medical assistance; and

(b) provide for the determination as to whether institutions and agencies meet the requirements for participation in the medical assistance program, and the certification that those requirements, including utilization review, are being met.

Subd. 2. **Existing procedures.** The policies and procedures, including survey forms, reporting forms, and other documents developed by the commissioner of health for the purpose of conducting the inspections of care required under Code of Federal Regulations, title 42, sections 456.600 to 456.614, in effect on March 1, 1984, have the force and effect of law and shall remain in effect and govern inspections of care until June 30, 1987, unless otherwise superseded by rules adopted by the commissioner of health.

144.076 MOBILE HEALTH CLINIC.

The state commissioner of health may establish, equip, and staff with the commissioner's own members or volunteers from the healing arts, or may contract with a public or private nonprofit agency or organization to establish, equip, and staff a mobile unit, or units to travel in and around poverty stricken areas and Indian reservations of the state on a prescribed course and schedule for diagnostic and general health counseling, including counseling on and distribution of dietary information, to persons residing in such areas. For this purpose the state commissioner of health may purchase and equip suitable motor vehicles, and furnish a driver and such other personnel as the department deems necessary to effectively carry out the purposes for which these mobile units were established or may contract with a public or private nonprofit agency or organization to provide the service.

144.146 TREATMENT OF CYSTIC FIBROSIS.

Subdivision 1. **Program.** The commissioner of health shall develop and conduct a program including medical care and hospital treatment for persons aged 21 or over who are suffering from cystic fibrosis.

144.1475 RURAL HOSPITAL DEMONSTRATION PROJECT.

Subdivision 1. **Establishment.** The commissioner of health, for the biennium ending June 30, 1999, shall establish at least three demonstration projects per fiscal year to assist rural hospitals in the planning and implementation process to either consolidate or cooperate with

another existing hospital in its service area to provide better quality health care to its community. A demonstration project must include at least two eligible hospitals. For purposes of this section, an "eligible hospital" means a hospital that:

(1) is located outside the seven-county metropolitan area;

(2) has 50 or fewer licensed beds; and

(3) is located within a 25-mile radius of another hospital.

At least one of the eligible hospitals in a demonstration project must have had a negative operating margin during one of the two years prior to application.

Subd. 2. **Application.** (a) An eligible hospital seeking to be a participant in a demonstration project must submit an application to the commissioner of health detailing the hospital's efforts to consolidate health care delivery in its service area, cooperate with another hospital in the delivery of health care, or both consolidate and cooperate. Applications must be submitted by October 15 of each fiscal year for grants awarded for that fiscal year.

(b) Applications must:

(1) describe the problem that the proposed consolidation or cooperation will address, the consolidation or cooperation project, how the grant funds will be used, what will be accomplished, and the results expected;

(2) describe achievable objectives, a timetable, and the roles and capabilities of responsible individuals and organizations;

(3) include written commitments from the applicant hospital and at least one other hospital that will participate in the consolidation or cooperation demonstration project, that specify the activities the organization will undertake during the project, the resources the organization will contribute to the demonstration project, and the expected role and nature of the organization's involvement in proposed consolidation or cooperation activities; and

(4) provide evidence of support for the proposed project from other local health service providers and from local community and government leaders.

Subd. 3. **Grants.** The commissioner of health shall allocate a grant of up to $100,000 to the highest scoring applicants each year until available funding is expended. Grants may be used by eligible hospitals to:

(1) conduct consolidation or cooperation negotiations;

(2) develop consolidation or cooperation plans, including financial plans and architectural designs;

(3) seek community input and conduct community education on proposed or planned consolidations or cooperative activities; and

(4) implement consolidation or cooperation plans.

Subd. 4. **Consideration of grants.** In evaluating applications, the commissioner shall score each application on a 100 point scale, assigning: a maximum of 40 points for an applicant's understanding of the problem, description of the project, and likelihood of successful outcome of the project; a maximum of 30 points for explicit and unequivocal written commitments from organizations participating in the project; a maximum of 20 points for matching funds or in-kind services committed by the applicant or others to the project; and a maximum of ten points for the extent of community support for the project. The commissioner shall consider the comments, if any, resulting from a review of the application by the community health board in whose community health service area the applicant is located. The commissioner may also take into account other relevant factors.

Subd. 5. **Evaluation.** The commissioner of health shall evaluate the overall effectiveness of the demonstration projects and report to the legislature by September 1, 2000. The commissioner may collect, from the hospitals receiving grants, any information necessary to evaluate the demonstration project.

144.443 TUBERCULOSIS HEALTH THREAT TO OTHERS.

A "health threat to others" as defined in section 144.4172, subdivision 8, includes a person who, although not currently infectious, has failed to complete a previously prescribed course of tuberculosis therapy, demonstrates an inability or unwillingness to initiate or complete, or shows an intent to fail to complete, a prescribed course of tuberculosis drug therapy, if that failure could lead to future infectiousness.

144.444 TUBERCULOSIS EMERGENCY HOLD.

A temporary emergency hold under section 144.4182 may be placed on a person who is a health threat to others when there is reasonable cause to believe that the person may be unlocatable

for the purposes of applying the procedures described in sections 144.4171 to 144.4186, or when medical or epidemiologic evidence suggests that the person is or may become infectious before the conclusion of court proceedings and appeals.

144.45 TUBERCULOSIS IN SCHOOLS; CERTIFICATE.

No person with active tuberculosis shall remain in or near a school building unless the person has a certificate issued by a physician stating that the person's presence in a school building will not endanger the health of other people.

145.132 AUTHORIZED REMOVAL OF BRAIN.

If the attending physician of a recipient of medical assistance is of the opinion that the deceased recipient was a victim of Alzheimer's disease, the physician or a designated pathologist may remove the brain of the decedent. Before the physician removes the brain, the physician shall obtain the permission of the decedent's next of kin, the authorization of the county coroner or medical examiner, and the authorization of the appropriate department of the St. Paul Ramsey Medical Center. The extracted brain shall be immediately transported to the St. Paul Ramsey Medical Center in a manner prescribed by the St. Paul Ramsey Medical Center.

145.97 HILL-BURTON PROGRAM; RECORD KEEPING.

The commissioner shall maintain records on the number and nature of complaints received and any actions taken to implement or enforce the Hill-Burton laws and rules.

145.98 COUNCIL ON HEALTH PROMOTION AND WELLNESS.

Subdivision 1. **Creation; membership.** The commissioner of health may appoint an Advisory Task Force on Health Promotion and Wellness. Members of the task force shall be experienced or interested in health promotion and wellness. There shall be at least one member from each congressional district. The task force shall expire, and the terms, compensation, and removal of members shall be governed by section 15.059.

Subd. 3. **Powers.** The task force may solicit, receive, and disburse funds made available for health promotion and wellness.