CHAPTER 62J

HEALTH CARE COST CONTAINMENT

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62J.03 DEFINITIONS.

[For text of subds 1 to 5, see M.S.1992]

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

[For text of subd 7, see M.S.1992]

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

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

History: *1993 c 345 art 3 s 1; art 4 s 1; art 6 s 1*

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

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

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

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

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

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

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

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

If the health care financing administration forecast for the total growth in national health expenditures for a calendar year is lower than the rate of growth for the calendar year as specified in clauses (1) to (5), the commissioner shall adopt this forecast as the growth limit for that calendar year. The commissioner shall adjust the growth limit set for calendar year 1995 to recover savings in health care spending required for the period July 1, 1993 to December 31, 1993. The commissioner shall publish:

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

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

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

Subd. 1a. **Adjusted growth limits and enforcement.** (a) The commissioner shall publish the final adjusted growth limit in the State Register by January 15 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to reflect differences between the actual regional consumer price index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to

the legislature by January 15 of each year on the projected increase in health care expenditures, the implementation of growth limits, and the reduction in the trend in the growth based on the limits imposed.

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

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

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

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

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

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

Subd. 3. **Cost containment duties.** After obtaining the advice and recommendations of the Minnesota health care commission, the commissioner shall:

(1) establish statewide and regional limits on growth in total health care spending under this section, monitor regional and statewide compliance with the spending limits, and take action to achieve compliance to the extent authorized by the legislature;

(2) divide the state into no fewer than four regions, with one of those regions being the Minneapolis/St. Paul metropolitan statistical area but excluding Chisago, Isanti, Wright, and Sherburne counties, for purposes of fostering the development of regional health planning and coordination of health care delivery among regional health care systems and working to achieve spending limits;

(3) provide technical assistance to regional coordinating boards;

(4) monitor the quality of health care throughout the state, conduct consumer satisfaction surveys, and take action as necessary to ensure an appropriate level of quality;

(5) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations, the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Health Care Financing Administration 1500 form, or other standardized forms or procedures;

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

(7) monitor and promote the development and implementation of practice parameters;

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

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

(10) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

(11) administer the health care analysis unit; and

(12) undertake other activities to monitor and oversee the delivery of health care services in Minnesota with the goal of improving affordability, quality, and accessibility of health care for all Minnesotans.

Subd. 4. **Consultation with the commission.** When the law requires the commissioner of health to consult with the Minnesota health care commission when undertaking any of the duties required under this chapter and chapter 62N, the commissioner shall consult with the commission and obtain the commission's advice and recommendations. If the commissioner intends to depart from the commission's recommendations, the commissioner shall inform the commission of the intended departure, provide a written explanation of the reasons for the departure, and give the commission an opportunity to comment on the intended departure. If, after receiving the commission's comment, the commissioner still intends to depart from the commission's recommendations, the commissioner shall notify each member of the legislative commission on health care access of the commissioner's intent to depart from the recommendations of the Minnesota health care commission. The notice to the legislative commission on health care access must be provided at least ten days before the commissioner takes final action. If emergency action is necessary that does not allow the commissioner to obtain the advice and recommendations of the Minnesota health care commission or to provide advance notice and an opportunity for comment as required in this subdivision, the commissioner shall provide a written notice and explanation to the Minnesota health care commission and the legislative commission on health care access at the earliest possible time.

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

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

Subd. 7. **Plan for controlling growth in spending.** (a) By January 15, 1993, the Minnesota health care commission shall submit to the legislature and the governor for approval a plan, with as much detail as possible, for slowing the growth in health care spending to the growth rate identified by the commissioner, beginning July 1, 1993. The goal of the plan shall be to reduce the growth rate of health care spending, adjusted for population changes, so that it declines by at least ten percent per year for each of the next five years. The plan may include tentative targets for reducing the growth in spending for consideration by the legislature.

(b) In developing the plan, the commission shall consider the advisability and feasibility of the following options, but is not obligated to incorporate them into the plan:

(1) data and methods that could be used to calculate regional and statewide spending limits and the various options for expressing spending limits, such as maximum percentage growth rates or actuarially adjusted average per capita rates that reflect the demographics of the state or a region of the state;

(2) methods of adjusting spending limits to account for patients who are not Min-

nesota residents, to reflect care provided to a person outside the person's region, and to adjust for demographic changes over time;

(3) methods that could be used to monitor compliance with the limits;

(4) criteria for exempting spending on research and experimentation on new technologies and medical practices when setting or enforcing spending limits;

(5) methods that could be used to help providers, purchasers, consumers, and communities control spending growth;

(6) methods of identifying activities of consumers, providers, or purchasers that contribute to excessive growth in spending;

(7) methods of encouraging voluntary activities that will help keep spending within the limits;

(8) methods of consulting providers and obtaining their assistance and cooperation and safeguards that are necessary to protect providers from abrupt changes in revenues or practice requirements;

(9) methods of avoiding, preventing, or recovering spending in excess of the rate of growth identified by the commission;

(10) methods of depriving those who benefit financially from overspending of the benefit of overspending, including the option of recovering the amount of the excess spending from the greater provider community or from individual providers or groups of providers through targeted assessments;

(11) methods of reallocating health care resources among provider groups to correct existing inequities, reward desirable provider activities, discourage undesirable activities, or improve the quality, affordability, and accessibility of health care services;

(12) methods of imposing mandatory requirements relating to the delivery of health care, such as practice parameters, hospital admission protocols, 24-hour emergency care screening systems, or designated specialty providers;

(13) methods of preventing unfair health care practices that give a provider or group purchaser an unfair advantage or financial benefit or that significantly circumvent, subvert, or obstruct the goals of this chapter;

(14) methods of providing incentives through special spending allowances or other means to encourage and reward special projects to improve outcomes or quality of care; and

(15) the advisability or feasibility of a system of permanent, regional coordinating boards to ensure community involvement in activities to improve affordability, accessibility, and quality of health care in each region.

Subd. 8. **Implementation plan.** (a) The commissioner, in consultation with the commission, shall develop and submit to the legislature and the governor by January 15, 1994, a detailed implementation plan, including proposed rules and legislation, to implement the cost containment plan recommended by the commission as described in the summary report of the commission issued on January 25, 1993, as further modified by Laws 1993, chapter 345. The goal of the implementation plan must be to allow integrated service networks to form beginning July 1, 1994, and to begin a phased-in implementation of an all-payer system over a two-year period beginning July 1, 1994.

(b) To ensure a wide range of choices for purchasers, consumers, and providers, the rules and legislation must encourage and facilitate the formation of locally controlled integrated service networks, in addition to networks sponsored by statewide health plan companies.

(c) Financial solvency, net worth, and reserve requirements for integrated service networks must facilitate the formation of new networks, including networks sponsored by providers, employers, community organizations, local governments, and other locally based organizations, while protecting enrollees from undue risk of financial insolvency. The rules and legislation shall authorize alternative financial solvency, net worth, and reserve requirements for networks sponsored by providers that are based on the operational capacity, facilities, personnel, and financial capability to provide the

services that it has contracted to provide to enrollees during the term of the contract provided the requirements are based on sound actuarial, financial, and accounting principles. The criteria for allowing integrated service networks and participating providers and health care providing entities to satisfy financial requirements through alternative means may authorize consideration of:

(1) the level of services to be provided by a provider relative to its existing service capacity;

(2) the provider's debt rating;

(3) certification by an independent consulting actuary;

(4) the availability of allocated or restricted funds;

(5) net worth;

(6) the availability of letters of credit;

(7) the taxing authority of the entity or governmental sponsor;

(8) net revenues;

(9) accounts receivable;

(10) the number of providers under contract;

(11) indebtedness; and

(12) other factors the commissioner may reasonably establish to measure the ability of the provider or health care providing entity to provide the level of services.

(d) The implementation plan may include a requirement that an integrated service network may not contract for management services with a separate entity unless:

(1) the contract complies with section 62D.19; and

(2) if the management contract exceeds five percent of gross revenues of the integrated service network, provisions requiring holdbacks or other risk-related provisions must be no more favorable to the separate entity under the management contract than comparable terms contained in any contract between the integrated service network and any health care providing entity or provider.

(e) The implementation plan must include technical assistance and financial assistance to promote the creation of locally controlled networks to serve rural areas and special populations. The commissioner and the commission shall consider including in the implementation plan the establishment of a management cooperative that will provide planning, organization, administration, billing, legal, and support services to integrated service networks that are members of the cooperative.

(f) The implementation plan must address problems of provider recruitment and retention in rural areas. Rules and legislation must be designed to improve the ability of rural communities to maintain an effective local delivery system.

(g) The implementation plan must include a method to create an option for health care providers and health care plans who meet or fall below the limits set by the commissioner under section 62J.04 to obtain a waiver from the applicability of the all-payer rules.

(h) In developing the implementation plan, the commissioner and the commission shall consider medical malpractice liability in terms of an entity operating an integrated service network and possible medical malpractice committed by its employees and make recommendations on any statutory changes that may be necessary. The commissioner may also consider whether a network and its participating entities should be allowed to reallocate between themselves the risk of malpractice liability.

(i) The implementation plan must identify the entities to whom an integrated service network may provide health care services, and persons or methods through whom or which an integrated service network may offer or sell its services.

(j) The implementation plan may consider the obligations that an integrated service network should have to the comprehensive health association established under section 62E.10. If obligations are to be required of an integrated service network, the implementation plan may provide for a phase-in of the assessments under section

62E.11. The implementation plan should clearly specify the rights and duties of integrated service networks with respect to the comprehensive health association.

(k) In developing the implementation plan, the commissioner and the commission shall consider how enrollees should be protected in the event of the insolvency of a network, how prospective enrollees should be informed of the consequences to enrollees of an insolvency, and the form of the hold harmless clause that must be contained in every network enrollee contract.

(l) In developing the implementation plan, the commissioner and the commission shall consider the liquidation, rehabilitation, and conservation procedures that would be appropriate for networks.

(m) The rules and legislation must include provisions authorizing integrated service networks to bear the risk of providing coverage either by retaining the risk or by transferring all or part of the risk by purchasing reinsurance or other appropriate methods.

(n) The implementation plan must recommend the solvency requirements appropriate for a network, including net worth and deposit requirements, any reduced or phased-in net worth or deposit requirements that might be appropriate for new networks, government-sponsored networks, networks that use accredited capitated providers, or that have other particular features that provide a rationale for adjusting the solvency requirements.

(o) The commissioner shall determine the possible relationships between providers and integrated service networks, including requirements for the contractual relationships that may be required in order to ensure flexible arrangements between integrated service networks and providers.

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

62J.045 MEDICAL EDUCATION AND RESEARCH COSTS.

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

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

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

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

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

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

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

History: *1993 c 345 art 3 s 5*

62J.05 MINNESOTA HEALTH CARE COMMISSION.

[For text of subds 1 to 4, see M.S.1992]

Subd. 5. [Repealed, 1993 c 247 art 1 s 21]

[For text of subds 6 to 8, see M.S.1992]

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

History: *1993 c 345 art 6 s 4*

62J.06 IMMUNITY FROM LIABILITY.

No member of the Minnesota health care commission established under section 62J.05, regional coordinating boards established under section 62J.09, health planning advisory committee established under section 62J.15, data collection advisory committee established under section 62J.30, or practice parameter advisory committee established under section 62J.32 shall be held civilly or criminally liable for an act or omission by that person if the act or omission was in good faith and within the scope of the member's responsibilities under this chapter.

History: *1993 c 247 art 1 s 7*

62J.09 REGIONAL COORDINATING BOARDS.

Subdivision 1. **General duties.** The regional coordinating boards are locally controlled boards consisting of providers, health plan companies, employers, consumers, and elected officials. Regional boards may:

(1) recommend that the commissioner approve voluntary agreements between providers in the region that will improve quality, access, or affordability of health care but might constitute a violation of antitrust laws if undertaken without government direction;

(2) make recommendations to the commissioner regarding major capital expenditures or the introduction of expensive new technologies and medical practices that are being proposed or considered by providers;

(3) undertake voluntary activities to educate consumers, providers, and purchasers or to promote voluntary, cooperative community cost containment, access, or quality of care projects;

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

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

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

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

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

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

(b) **Provider representatives.** Each regional board must include four members representing health care providers who practice in the region. One member is appointed by the Minnesota Medical Association. One member is appointed by the Minnesota Hospital Association. One member is appointed by the Minnesota Nurses' Association. The remaining member is appointed by the governor to represent providers other than physicians, hospitals, and nurses.

(c) **Health plan company representatives.** Each regional board includes four members representing health plan companies who provide coverage for residents of the region, including one member representing health insurers who is elected by a vote of all health insurers providing coverage in the region, one member elected by a vote of all health maintenance organizations providing coverage in the region, and one member appointed by Blue Cross and Blue Shield of Minnesota. The fourth member is appointed by the governor.

(d) **Employer representatives.** Regional boards include three members representing employers in the region. Employer representatives are elected by a vote of the employers who are members of chambers of commerce in the region. At least one member must represent self-insured employers.

(e) **Employee unions.** Regional boards include one member appointed by the AFL-CIO Minnesota who is a union member residing or working in the region or who is a representative of a union that is active in the region.

(f) **Public members.** Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the state legislators with districts in the region. One consumer member is appointed by the governor.

(g) **County commissioner.** Regional boards include one member who is a county board member. The county board member is elected by a vote of all of the county board members in the region, with each county board having one vote.

(h) **State agency.** Regional boards include one state agency commissioner appointed by the governor to represent state health coverage programs.

Subd. 3. [Repealed, 1993 c 247 art 1 s 21]

[For text of subd 4, see M.S.1992]

Subd. 5. **Conflicts of interest.** No member may vote in regional coordinating board proceedings involving an individual provider, purchaser, or patient, or a specific activity or transaction, if the member has a direct financial interest in the outcome of the regional coordinating board's proceedings other than as an individual consumer of health care services. A member with a direct financial interest may participate in the proceedings, without voting, provided that the member discloses any direct financial interest to the regional coordinating board at the beginning of the proceedings.

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

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

[For text of subd 7, see M.S.1992]

Subd. 8. **Repealer.** This section is repealed effective July 1, 1996.

History: *1993 c 247 art 1 s 8-10; 1993 c 345 art 3 s 6; art 6 s 5-8*

62J.15 HEALTH PLANNING.

Subdivision 1. **Health technology advisory committee.** The Minnesota health care commission shall convene an advisory committee to conduct evaluations of existing

research and technology assessments conducted by other entities of new and existing health care technologies. The advisory committee may include members of the state commission and other persons appointed by the commission. The advisory committee must include at least one person representing physicians, at least one person representing hospitals, and at least one person representing the health care technology industry. Health care technologies include high-cost drugs, devices, procedures, or processes applied to human health care, such as high-cost transplants and expensive scanners and imagers. The advisory committee is governed by section 15.0575, subdivision 3, except that members do not receive per diem payments.

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

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

History: *1993 c 345 art 4 s 2,3*

NOTE: Subdivision 2 was also amended by Laws 1993, chapter 247, article 1, section 11, to read as follows:

"Subd. 2. **Health planning.** In consultation with the health planning advisory committee, the Minnesota health care commission shall:

(1) make recommendations on the types of high-cost technologies, procedures, and capital expenditures for which a plan on statewide use and distribution should be made;

(2) develop criteria for evaluating new high-cost health care technology and procedures and major capital expenditures that take into consideration the clinical effectiveness, cost-effectiveness, and health outcome;

(3) recommend to the commissioner of health and the regional coordinating boards statewide and regional goals and targets for the distribution and use of new and existing high-cost health care technologies and procedures and major capital expenditures;

(4) make recommendations to the commissioner regarding the designation of referral centers for transplants and other specialized medical procedures; and

(5) make recommendations to the commissioner regarding minimum volume requirements for the performance of certain procedures by hospitals and other health care facilities or providers."

62J.152 DUTIES OF HEALTH TECHNOLOGY ADVISORY COMMITTEE.

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

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

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

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

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

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

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

(2) the cost implications;

(3) the potential for rapid diffusion;

(4) the impact on a substantial patient population;

(5) the existence of alternative technologies;

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

(7) the public health importance;

(8) the level of public and professional demand;

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

(10) the prevalence of the disease or condition.

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

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

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

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

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

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

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

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

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

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

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

(6) by consumers in making decisions about treatment;

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

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

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

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

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

History: *1993 c 345 art 4 s 4*

62J.156 CLOSED COMMITTEE HEARINGS.

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

History: *1993 c 345 art 4 s 5*

62J.17 EXPENDITURE REPORTING.

[For text of subd 1, see M.S.1992]

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

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

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

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

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

(e) **Health care service.** "Health care service" means:

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

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

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

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

(1) acquisition of a unit of medical equipment;

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

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

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

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

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

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

(1) an extracorporeal shock wave lithotripter;

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

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

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

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

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

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

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

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

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

[For text of subd 3, see M.S.1992]

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

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

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

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

(2) the date of the major spending commitment;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(d) **Exceptions.** The prospective review and approval process does not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state;

(2) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school or by a federal or foundation grant, or clinical trials;

(3) a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and

(4) mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

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

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

History: *1993 c 345 art 6 s 9-12*

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

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

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

"Subd. 4. **Expenditure reporting.** Any provider making a major spending commitment after April 1, 1992, that is in excess of $500,000, shall submit notification of this expenditure to the commissioner within 60 days of making the major spending commitment and provide the commissioner with any relevant background or other information. The commissioner shall not have any approval or denial authority, but should use such information in the ongoing evaluation of statewide and regional progress toward cost containment and other objectives.

Subd. 5. **Retrospective review.** The commissioner of health, in consultation with the Minnesota health care commission, shall retrospectively review capital expenditures and major spending commitments that are required to be reported by providers under subdivision 4. In the event that health care providers refuse to cooperate with attempts by the Minnesota health care commission and regional coordinating boards to coordinate the use of health care technologies and procedures, and reduce the growth rate in health care expenditures; or in the event that health care providers use, purchase, or perform health care technologies and procedures that are not clinically effective and cost-effective; or in the event providers have failed to pursue lawful collaborative arrangements; the commissioner shall require those health care providers to follow the procedures for prospective review and approval established in subdivision 6.

Subd. 6. **Prospective review and approval.** (a) **Requirement.** The commissioner shall prohibit those health care providers subject to retrospective review under subdivision 5 from making future major spending commitments or capital expenditures that are required to be reported under subdivision 4 for a period of up to five years, unless: (1) the provider has filed an application to proceed with the major spending commitment or capital expenditure with the commissioner and provided supporting documentation and evidence requested by the commissioner; and (2) the commissioner determines, based upon this documentation and evidence, that the spending commitment or capital expenditure is appropriate. The commissioner shall make a decision on a completed application within 60 days after an application is submitted. The Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, and health care expenditures to review applications and make recommendations to the commissioner and the commission.

(b) **Exceptions.** This subdivision does not apply to:

(1) a major spending commitment to replace existing equipment with comparable equipment, if the old equipment will no longer be used in the state;

(2) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant, or clinical trials;

(3) a major spending commitment to repair, remodel, or replace existing buildings or fixtures if, in the judgment of the commissioner, the project does not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided; and

(4) mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

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

62J.19 SUBMISSION OF REGIONAL PLAN TO COMMISSIONER.

Each regional coordinating board shall submit its plan to the commissioner on or before June 30, 1993.

History: *1993 c 247 art 1 s 16*

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

62J.212 COLLABORATION ON PUBLIC HEALTH GOALS.

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

History: *1993 c 345 art 5 s 9*

62J.23 PROVIDER CONFLICTS OF INTEREST.

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

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

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

Subd. 4. **Integrated service networks.** (a) The legislature finds that the formation and operation of integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of integrated service networks. The legislature finds that the federal Medicare antikickback laws should not be

interpreted to interfere with the development of integrated service networks or to impose liability for arrangements between an integrated service network and its participating entities.

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

History: *1993 c 247 art 1 s 17; 1993 c 345 art 6 s 13*

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

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

"Subdivision 1. **Purpose.** The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by some cooperative arrangements involving providers or purchasers that may be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of this section is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the competitive marketplace. The legislature intends that approval of relationships be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that this approval will make relationships immune from state and federal antitrust liability.

Subd. 4. **State antitrust law.** Notwithstanding the Minnesota antitrust law of 1971, as amended, in sections 325D.49 to 325D.66, contracts, business or financial arrangements, or other activities, practices, or arrangements involving providers or purchasers that are approved by the commissioner under this section do not constitute an unlawful contract, combination, or conspiracy in unreasonable restraint of trade or commerce under sections 325D.49 to 325D.66. Approval by the commissioner is an absolute defense against any action under state antitrust laws."

ANTITRUST EXCEPTIONS

62J.2911 ANTITRUST EXCEPTIONS; PURPOSE.

The legislature finds that the goals of controlling health care costs and improving the quality of and access to health care services will be significantly enhanced by cooperative arrangements involving providers or purchasers that might be prohibited by state and federal antitrust laws if undertaken without governmental involvement. The purpose of sections 62J.2911 to 62J.2921 is to create an opportunity for the state to review proposed arrangements and to substitute regulation for competition when an arrangement is likely to result in lower costs, or greater access or quality, than would otherwise occur in the marketplace. The legislature intends that approval of arrangements be accompanied by appropriate conditions, supervision, and regulation to protect against private abuses of economic power, and that an arrangement approved by the commissioner and accompanied by such appropriate conditions, supervision, and regulation shall not be subject to state and federal antitrust liability.

History: *1993 c 345 art 6 s 14*

62J.2912 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

History: *1993 c 345 art 6 s 15*

62J.2913 SCOPE.

Subdivision 1. **Availability of exception.** Providers or purchasers wishing to engage in contracts, business or financial arrangements, or other activities, practices, or arrangements that might be construed to be violations of state or federal antitrust laws but which are in the best interests of the state and further the policies and goals of this chapter may apply to the commissioner for an exception.

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

Subd. 3. **Application cannot be used to impose liability.** The commissioner may ask the attorney general to comment on an application. The application and any information obtained by the commissioner under sections 62J.2914 to 62J.2916 that is not otherwise available is not admissible in any civil or criminal proceeding brought by the attorney general or any other person based on an antitrust claim, except:

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

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

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

History: *1993 c 345 art 6 s 16*

62J.2914 APPLICATION.

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

(1) a descriptive title;

(2) a table of contents;

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

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

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

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

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

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

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

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

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

(vi) identification of whether any services or products of the proposed arrange-

ment are currently being offered, capable of being offered, utilized, or capable of being utilized by other providers or purchasers in the geographic territory described in item (iii);

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

History: *1993 c 345 art 6 s 17*

62J.2915 NOTICE AND COMMENT.

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

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

History: *1993 c 345 art 6 s 18*

62J.2916 PROCEDURE FOR REVIEW OF APPLICATIONS.

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

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

(2) the complexity of the proposed arrangement;

(3) the novelty of the proposed arrangement;

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

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

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

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

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

(b) **Limited hearing.** (1) The commissioner may order a limited hearing. A copy of the order must be mailed to the applicant and to all persons who have submitted

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

(2) The limited hearing must be held before the commissioner or department of health staff member designated by the commissioner. The commissioner or the commissioner's designee shall question the applicant about the evidence submitted by the applicant. The questions may address relevant issues identified in the comments submitted in response to the written evidence or identified by department of health staff or brought to light by department of health data. At the conclusion of the applicant's responses to the questions, any person who submitted comments about the applicant's written evidence may make a statement addressing the applicant's responses to the questions. The commissioner or the commissioner's designee may ask questions of any person making a statement. At the conclusion of all statements, the applicant may make a closing statement.

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

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

History: *1993 c 345 art 6 s 19*

62J.2917 CRITERIA FOR DECISION.

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

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

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

(2) market structure:

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

(ii) actual and potential consumers;

(iii) geographic market area; and

(iv) entry conditions;

(3) current market conditions;

(4) the historical behavior of the market;

(5) performance of other, similar arrangements;

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

(7) the financial condition of the applicant.

(b) **Cost.** The commissioner's analysis of cost must focus on the individual consumer of health care. Cost savings to be realized by providers, health carriers, group purchasers, or other participants in the health care system are relevant only to the extent that the savings are likely to be passed on to the consumer. However, where an application is submitted by providers or purchasers who are paid primarily by third party payers unaffiliated with the applicant, it is sufficient for the applicant to show that cost savings are likely to be passed on to the unaffiliated third party payers; the applicants do not have the burden of proving that third party payers with whom the applicants are not affiliated will pass on cost savings to individuals receiving coverage through the third party payers. In making determinations as to costs, the commissioner may consider:

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

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

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

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

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

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

(7) likely effectiveness of regulation by the commissioner;

(8) inferences to be drawn from market structure;

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

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

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

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

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

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

If the commissioner determines that the proposed arrangement is likely to increase access and bases that determination on a projected increase in utilization, the commis-

sioner shall also determine and make a specific finding that the increased utilization does not reflect overutilization.

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

(1) decrease morbidity and mortality;

(2) result in faster convalescence;

(3) result in fewer hospital days;

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

(5) increase patient satisfaction; and

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

History: *1993 c 345 art 6 s 20*

62J.2918 DECISION.

Subdivision 1. **Approval or disapproval.** The commissioner shall issue a written decision approving or disapproving the application. The commissioner may condition approval on a modification of all or part of the proposed arrangement to eliminate any restriction on competition that is not reasonably related to the goals of reducing cost or improving access or quality. The commissioner may also establish conditions for approval that are reasonably necessary to protect against abuses of private economic power and to ensure that the arrangement is appropriately supervised and regulated by the state.

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

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

History: *1993 c 345 art 6 s 21*

62J.2919 APPEAL.

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

History: *1993 c 345 art 6 s 22*

62J.2920 SUPERVISION AFTER APPROVAL.

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

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

pliance with the commissioner's order, the commissioner shall identify those respects in which the arrangement does not conform to the commissioner's order.

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

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

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

History: *1993 c 345 art 6 s 23*

62J.2921 REVOCATION.

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

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

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

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

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

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

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

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

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

History: *1993 c 345 art 6 s 24*

62J.30 HEALTH CARE ANALYSIS UNIT.

Subdivision 1. **Definitions.** For purposes of sections 62J.30 to 62J.34, the following definitions apply:

(a) "Practice parameter" means a statement intended to guide the clinical decision making of health care providers and patients that is supported by the results of appropriately designed outcomes research studies or that has been approved by the federal agency for health care policy and research or adopted for use by the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, or a board approved by the American Dental Association.

(b) "Outcomes research" means research designed to identify and analyze the outcomes and costs of alternative interventions for a given clinical condition, in order to determine the most appropriate and cost-effective means to prevent, diagnose, treat, or manage the condition, or in order to develop and test methods for reducing inappropriate or unnecessary variations in the type and frequency of interventions.

[For text of subds 2 and 3, see M.S.1992]

Subd. 4. **Criteria for unit initiatives.** Data and research initiatives by the health care analysis unit must:

(1) serve the needs of the general public, public sector health care programs, employers and other purchasers of health care, health care providers, including providers serving large numbers of low-income people, and health carriers;

(2) promote a significantly accelerated pace of publicly disseminated, applied research on health care delivery, outcomes, costs, quality, and management;

(3) conduct research and promote health care applications based on scientifically sound and statistically valid methods;

(4) be statewide in scope, to the extent feasible, in order to benefit health care purchasers and providers in all parts of Minnesota and to ensure a broad and representative data base for research, comparisons, and applications;

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

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

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

[For text of subd 5, see M.S.1992]

Subd. 6. **Data collection procedures.** The health care analysis unit shall collect data from health care providers, health carriers, and individuals in the most cost-effective manner, which does not unduly burden them. The unit may require health care providers and health carriers to collect and provide all patient health records and claim files,

and cooperate in other ways with the data collection process. The unit may also require health care providers and health carriers to provide mailing lists of patients who have consented to release of data. The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plans when reporting data under this chapter. The data analysis unit must code patient identifiers to prevent identification and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and section 144.335.

Subd. 7. **Data classification.** (a) Data collected through the large-scale data base initiatives of the health care analysis unit required by section 62J.31 that identify individual patients or providers are private data on individuals. Data not on individuals are nonpublic data. The commissioner may release private data on individuals and nonpublic data to researchers affiliated with university research centers or departments who are conducting research on health outcomes, practice parameters, and medical practice style; researchers working under contract with the commissioner; and individuals purchasing health care services for health carriers and groups. The commissioner shall require any person or organization receiving under this subdivision either private data on individuals or nonpublic data to sign an agreement to maintain the data that it receives according to the statutory provisions applicable to the data. The agreement shall not limit the preparation and dissemination of summary data as permitted under section 13.05, subdivision 7. To the extent reasonably possible, release of private, confidential, or nonpublic data under this chapter shall be made without releasing data that identifies patients and should instead be released using the identification numbers required by subdivision 6.

(b) Summary data derived from data collected through the large-scale data base initiatives of the health care analysis unit may be provided under section 13.05, subdivision 7, and may be released in studies produced by the commissioner.

(c) The commissioner shall adopt rules to establish criteria and procedures to govern access to and the use of data collected through the initiatives of the health care analysis unit.

Subd. 8. **Data collection advisory committee.** (a) The commissioner shall convene a 15-member data collection advisory committee consisting of health service researchers, health care providers, health carrier representatives, representatives of businesses that purchase health coverage, and consumers. Six members of this committee must be health care providers. The advisory committee shall evaluate methods of data collection and shall recommend to the commissioner methods of data collection that minimize administrative burdens, address data privacy concerns, and meet the needs of health service researchers. The advisory committee is governed by section 15.059, except that its existence does not terminate and members do not receive per diem compensation.

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

[For text of subd 9, see M.S.1992]

Subd. 10. **Contracts and grants.** To carry out the duties assigned in sections 62J.30 to 62J.34, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data.

[For text of subd 11, see M.S.1992]

History: *1993 c 247 art 5 s 1-4; 1993 c 345 art 12 s 1-4*

62J.31 LARGE-SCALE DATABASE.

[For text of subd 1, see M.S.1992]

Subd. 2. **Specific health conditions.** (a) Data collected under this section must be collected for specific health conditions, rather than specific procedures, types of health care providers, or services. The health care analysis unit shall designate a limited number of specific health conditions for which data shall be collected during the first year of operation. For subsequent years, data may be collected for additional specific health conditions. The number of specific conditions for which data is collected is subject to the availability of appropriations.

(b) The initiative must emphasize conditions that account for significant total costs, when considering both the frequency of a condition and the unit cost of treatment. The initial emphasis must be on the study of conditions commonly treated in hospitals on an inpatient or outpatient basis, or in freestanding outpatient surgical centers. This initial emphasis may be expanded to include entire episodes of care for a given condition, whether or not treatment includes use of a hospital or a freestanding outpatient surgical center, if adequate data collection and evaluation techniques are available for that condition.

Subd. 3. **Information to be collected.** The data collected must include information on health outcomes, including information on mortality, morbidity, patient functional status and quality of life, symptoms, and patient satisfaction. The data collected must include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records, as provided in section 62J.30, subdivisions 6 and 7. The data must be collected in a manner that allows comparisons to be made between providers, health carriers, public programs, and other entities.

[For text of subds 4 and 5, see M.S.1992]

History: *1993 c 247 art 5 s 5,6*

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

Subdivision 1. **Data analysis.** The health care analysis unit shall analyze the data collected through the large-scale database using existing practice parameters and newly researched practice parameters, including those established through the outcomes research studies of the federal government. The unit may use the data collected to develop new practice parameters, if development and refinement is based on input from and analysis by practitioners, particularly those practitioners knowledgeable about and impacted by practice parameters. The unit may also refine existing practice parameters, and may encourage or coordinate private sector research efforts designed to develop or refine practice parameters.

[For text of subds 2 and 3, see M.S.1992]

Subd. 4. **Practice parameter advisory committee.** (a) The commissioner shall convene a 15-member practice parameter advisory committee comprised of eight health care professionals, and representatives of the research community and the medical technology industry. The committee shall present recommendations on the adoption of practice parameters to the commissioner and the Minnesota health care commission and provide technical assistance as needed to the commissioner and the commission. The advisory committee is governed by section 15.059, except that its existence does not terminate and members do not receive per diem compensation.

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

History: *1993 c 247 art 5 s 7,8; 1993 c 345 art 12 s 5*

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

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

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

(2) prices, outcomes, provider experience, and other information for services less commonly covered by insurance or for which patients commonly face significant out-of-pocket expenses; and

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

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

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

History: *1993 c 345 art 3 s 7*

62J.34 OUTCOME-BASED PRACTICE PARAMETERS.

[For text of subd 1, see M.S.1992]

Subd. 2. **Approval.** The commissioner of health, after receiving the advice and recommendations of the Minnesota health care commission, may approve practice parameters that are endorsed, developed, or revised by the health care analysis unit. The commissioner is exempt from the rulemaking requirements of chapter 14 when approving practice parameters approved by the federal agency for health care policy and research, practice parameters adopted for use by the American Medical Association, the National Medical Association, a member board of the American Board of Medical Specialties, a board approved by the American Osteopathic Association, a college or board approved by the Royal College of Physicians and Surgeons of Canada, a national health professional board or association, a board approved by the American Dental Association. The commissioner shall use rulemaking to approve practice parameters that are newly developed or substantially revised by the health care analysis unit. Notice of adoption of practice parameters adopted without rulemaking must be published in the State Register and must include a statement that the complete practice parameter is available free of charge from the commissioner.

Subd. 3. **Medical malpractice cases.** (a) In an action against a provider for malpractice, error, mistake, or failure to cure, whether based in contract or tort, adherence to

a practice parameter approved by the commissioner of health under subdivision 2 is an absolute defense against an allegation that the provider did not comply with accepted standards of practice in the community.

(b) Evidence of a departure from a practice parameter is admissible only on the issue of whether the provider is entitled to an absolute defense under paragraph (a).

(c) Paragraphs (a) and (b) apply to claims arising on or after August 1, 1993, or 90 days after the date the commissioner approves the applicable practice parameter, whichever is later.

(d) Nothing in this section changes the standard or burden of proof in an action alleging a delay in diagnosis, a misdiagnosis, inappropriate application of a practice parameter, failure to obtain informed consent, battery or other intentional tort, or product liability.

History: *1993 c 247 art 5 s 9,10; 1993 c 345 art 12 s 6*

62J.35 DATA COLLECTION.

Subdivision 1. **Data collection by commissioner.** For purposes of forecasting rates of growth in health care spending and setting limits under section 62J.04, subdivisions 1 and 1a, the commissioner may collect from health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

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

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

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

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

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

62J.37 DATA FROM INTEGRATED SERVICE NETWORKS.

The commissioner shall require integrated service networks operating under section 62N.06, subdivision 1, to submit data on health care spending and revenue for calendar year 1994 by February 15, 1995. Each February 15 thereafter, integrated service networks shall submit to the commissioner data on health care spending and revenue

for the preceding calendar year. The data must be provided in the form specified by the commissioner. To the extent that an integrated service network is operated by a group purchaser under section 62N.06, subdivision 2, the integrated service network is exempt from this section and the group purchaser must provide data on the integrated service network under section 62J.38.

History: *1993 c 345 art 3 s 9*

62J.38 DATA FROM GROUP PURCHASERS.

(a) The commissioner shall require group purchasers to submit detailed data on total health care spending for calendar years 1990, 1991, and 1992, and for calendar year 1993 and successive calendar years. Group purchasers shall submit data for the 1993 calendar year by February 15, 1994, and each April 1 thereafter shall submit data for the preceding calendar year.

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

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

History: *1993 c 345 art 3 s 10*

62J.40 DATA FROM STATE AGENCIES.

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

History: *1993 c 345 art 3 s 11*

62J.41 DATA FROM PROVIDERS.

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

(1) the total number of patients served;

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

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

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

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

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

(7) revenue from research activities;

(8) revenue from educational activities;

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

(10) revenue from donations; and

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

Subd. 2. **Annual monitoring and estimates.** The commissioner shall require health care providers to submit the required data for the period July 1, 1993 to December 31, 1993, by February 15, 1994. Health care providers shall submit data for the 1994 calendar year by February 15, 1995, and each February 15 thereafter shall submit data for the preceding calendar year. The commissioner of revenue may collect health care service revenue data from health care providers, if the commissioner of revenue and the commissioner agree that this is the most efficient method of collecting the data. The commissioner of revenue shall provide any data collected to the commissioner of health.

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

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

History: *1993 c 345 art 3 s 12*

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

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

History: *1993 c 345 art 3 s 13*

62J.44 PUBLICATION OF DATA.

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

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

History: *1993 c 345 art 3 s 14*

62J.45 DATA INSTITUTE.

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

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

The data institute created in this section will be a partnership between the commissioner of health and a board of directors representing health carriers and other group purchasers, health care providers, and consumers. These entities will work together to establish a centralized cost and quality data system that will be used by the public and private sectors. The data collection advisory committee and the practice parameter advisory committee shall provide assistance to the institute through the commissioner of health.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

This plan shall be prepared by October 31, 1993.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(1) the purpose of initiating data collection initiatives;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

collect and validate the data. Any contract must require the private sector entity to maintain the data collected according to the data privacy provisions applicable to the data.

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

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

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

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

History: *1993 c 345 art 3 s 15*

62J.46 MONITORING AND REPORTS.

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

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

History: *1993 c 345 art 3 s 16*