CHAPTER 62J

HEALTH CARE COST CONTAINMENT

62J.01 FINDINGS.

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

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

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

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

History: *1989 c 327 s 1*

COST CONTROLS

62J.015 PURPOSE.

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

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

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

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

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

62J.016 GOALS OF RESTRUCTURING.

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

History: *1994 c 625 art 1 s 1*

62J.017 IMPLEMENTATION TIMETABLE.

The state seeks to complete the restructuring of the health care delivery and financing system. Beginning July 1, 1994, measures will be taken to increase the public accountability of existing health plan companies, to promote the development of small, community–based integrated service networks, and to reduce administrative costs by standardizing third–party billing forms and procedures and utilization review requirements. Voluntary formation of other integrated service networks will begin after rules have been adopted, but not before July 1, 1996. Statutes and rules for the restructured health care financing and delivery system must be enacted or adopted by January 1, 1996.

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

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

62J.03 DEFINITIONS.

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

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

Subd. 3. **Commission.** "Commission" or "state commission" means the Minnesota health care commission established in section 62J.05.

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

Subd. 5. **Cost–effective.** "Cost–effective" means that the economic costs of using a particular technology to achieve improvement in a patient's health outcome are justified given a comparison to both the economic costs and the improvement in patient health outcome resulting from the use of alternative technologies.

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

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

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

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

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

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

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.

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 31 of the year that the expenditure limit is to be in effect. The adjusted limit must reflect the actual regional consumer price index for urban consumers for the previous calendar year, and may deviate from the previously published projected growth limits to reflect differences between the actual regional consumer price index for urban consumers and the projected Consumer Price Index for urban consumers. The commissioner shall report to the legislature by February 15 of each year on the implementation of the growth limits. This annual report shall describe the differences between the projected increase in health care expenditures, the actual expenditures based on data collected, and the impact and validity of growth limits within the overall health care reform strategy.

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

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

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

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

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

(c) The commissioner shall enforce limits on growth in spending for health plan companies and revenues for providers. If the commissioner determines that artificial inflation or padding of costs or prices has occurred in anticipation of the implementation of growth limits, the commissioner may adjust the base year spending totals or growth limits or take other action to reverse the effect of the artificial inflation or padding.

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

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

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

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

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

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

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

(3) provide technical assistance to regional coordinating boards;

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

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

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

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

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

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

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

Subd. 9. **Growth limits; federal programs.** The commissioners of health and human services shall establish a rate methodology for Medicare and Medicaid risk–based contract-

ing with health plan companies that is consistent with statewide growth limits. The methodology shall be presented for review by the Minnesota health care commission and the legislative commission on health care access prior to the submission of a waiver request to the health care financing administration and subsequent implementation of the methodology.

History: *1992 c 549 art 1 s 3; 1993 c 247 art 1 s 1–6; 1993 c 345 art 1 s 1; art 3 s 2–4,18; art 5 s 7,8; art 6 s 2,3; 1994 c 625 art 8 s 16–18; 1995 c 234 art 3 s 2; art 5 s 2*

62J.041 INTERIM HEALTH PLAN COMPANY EXPENDITURE LIMITS.

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

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

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

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

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

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

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

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

Subd. 4. **Monitoring of reserves.** (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner re-

spectively regulates to ensure that savings resulting from the establishment of expenditure limits are passed on to consumers in the form of lower premium rates.

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

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal year. These health plan companies shall submit with required quarterly financial statements a calculation of the actual reserve level attained by the company at the end of each quarter including identification of the sources of any significant changes in the reserve level and an updated projection of the level of reserves the health plan company expects to attain by the end of the fiscal year. In cases where the health plan company has been given a certificate to operate a new health maintenance organization under chapter 62D, or been licensed as an integrated service network or community integrated service network under chapter 62N, or formed an affiliation with one of these organizations, the health plan company shall also submit with its quarterly financial statement, total enrollment at the beginning and end of the quarter and enrollment changes within each service area of the new organization. The reserve calculations shall be maintained by the commissioners as trade secret information, except to the extent that such information is also required to be filed by another provision of state law and is not treated as trade secret information under such other provisions.

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

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

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

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

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

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

(2) trend assumptions used in setting future premiums;

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

(4) proposed rate increases or decreases;

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

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

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

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

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

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

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

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

(c) Health plan companies that exceed the expenditure limits based on two–year average expenditure data (1994 and 1995, 1996 and 1997) shall be required by the appropriate commissioner to pay back the amount exceeding the expenditure limit through an assessment on the health plan company. A health plan company may appeal the commissioner's order to pay back the amount exceeding the expenditure limit by mailing to the commissioner a written notice of appeal within 30 days from the date the commissioner's order was mailed. The contested case and judicial review provisions of chapter 14 apply to the appeal. The health plan company shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 15.472 to 15.475, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund. The appropriate commissioner may approve a different repayment method to take into account the health plan company's financial condition. Health plan companies shall comply with the limits but shall also guarantee that their contractual obligations are met. Health plan companies are prohibited from meeting spending obligations by increasing subscriber liability, including copayments and deductibles and amounts in excess of benefit plan maximums.

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

62J.042 HEALTH CARE PROVIDER REVENUE LIMITS.

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

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

to the commissioner, and approved by the commissioner as actuarially justified. The methodology to be used for adjustments must be submitted to the commissioner by September 1, 1994. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.

Subd. 3. **Monitoring of revenue.** The commissioner of health shall monitor health care provider revenue, to ensure that savings resulting from the establishment of revenue limits are passed on to consumers in the form of lower charges. The commissioner shall monitor hospital revenue by examining net inpatient revenue per adjusted admission and net outpatient revenue per outpatient visit. The commissioner shall monitor the revenue of physicians and other health care providers by examining revenue per patient per year or revenue per encounter. For purposes of this section, definitions related to the implementation of limits for providers other than hospitals are included in Minnesota Rules, chapter 4650, and definitions related to the implementation of limits for hospitals are included in Minnesota Rules, chapter 4651. If this information is not available, the commissioner may enforce an annual limit on the rate of growth of the provider's current fees.

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

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

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

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

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

A provider may appeal the commissioner's order to pay back the amount exceeding the revenue or fee limit by mailing a written notice of appeal to the commissioner within 30 days after the commissioner's order was mailed. The contested case and judicial review provi-

sions of chapter 14 apply to the appeal. The provider shall pay the amount specified by the commissioner either to the commissioner or into an escrow account until final resolution of the appeal. Notwithstanding sections 15.472 to 15.475, each party is responsible for its own fees and expenses, including attorneys fees, for the appeal. Any amount required to be paid back under this section shall be deposited in the health care access fund.

Subd. 5. **Small rural hospitals.** Each small rural hospital shall file information with the commissioner of health and calculate its growth in revenues pursuant to the requirements of this chapter. Small rural hospitals that do not file as part of a hospital system are exempt from the repayment provisions of subdivision 4. However, the commissioner retains the authority to initiate an investigation and order repayment pursuant to this section, if the commissioner believes that there is an unreasonable rate of growth in revenues and if the hospital fails to demonstrate good cause for exceeding the statutory growth limits. For purposes of this subdivision, small rural hospital is defined as a hospital with less than 50 licensed beds.

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

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

62J.05 MINNESOTA HEALTH CARE COMMISSION.

Subdivision 1. **Purpose of the commission.** The Minnesota health care commission consists of health care providers, purchasers, consumers, employers, and employees. The two major functions of the commission are:

(1) to make recommendations to the commissioner of health and the legislature regarding statewide and regional limits on the rate of growth of health care spending and activities to prevent or address spending in excess of the limits; and

(2) to help Minnesota communities, providers, group purchasers, employers, employees, and consumers improve the affordability, quality, and accessibility of health care.

Subd. 2. **Membership.** (a) **Number.** The Minnesota health care commission consists of 28 members, as specified in this subdivision. A member may designate a representative to act as a member of the commission in the member's absence. The governor and legislature shall coordinate appointments under this subdivision to ensure gender balance and ensure that geographic areas of the state are represented in proportion to their population.

(b) **Health plan companies.** The commission includes four members representing health plan companies, including one member appointed by the Minnesota Council of Health Maintenance Organizations, one member appointed by the Insurance Federation of Minnesota, one member appointed by Blue Cross and Blue Shield of Minnesota, and one member appointed by the governor.

(c) **Health care providers.** The commission includes six members representing health care providers, including one member appointed by the Minnesota Hospital Association, one member appointed by the Minnesota Medical Association, one member appointed by the Minnesota Nurses' Association, one rural physician appointed by the governor, and two members appointed by the governor to represent providers other than hospitals, physicians, and nurses.

(d) **Employers.** The commission includes four members representing employers, including (1) two members appointed by the Minnesota Chamber of Commerce, including one self–insured employer and one small employer; and (2) two members appointed by the governor.

(e) **Consumers.** The commission includes seven consumer members, including three members appointed by the governor, one of whom must represent persons over age 65; one member appointed by the consortium of citizens with disabilities to represent consumers with physical disabilities or chronic illness; one member appointed by the mental health association of Minnesota, in consultation with the Minnesota chapter of the society of Americans for recovery, to represent consumers with mental illness or chemical dependency; one appointed under the rules of the senate; and one appointed under the rules of the house of representatives.

(f) **Employee unions.** The commission includes three representatives of labor unions, including two appointed by the AFL–CIO Minnesota and one appointed by the governor to represent other unions.

(g) **State agencies.** The commission includes the commissioners of commerce, employee relations, and human services.

(h) **Regional coordinating boards.** The commission includes one member who is the chair of a regional coordinating board, elected by a majority vote of the chairs of the regional coordinating boards.

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

Subd. 3. **Financial interests of members.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

Subd. 4. **Conflicts of interest.** No member may participate or vote in commission 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 commission's proceedings other than as an individual consumer of health care services.

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

Subd. 6. **Terms; compensation; removal; and vacancies.** The commission is governed by section 15.0575.

Subd. 7. **Administration.** The commissioner of health shall provide office space, equipment and supplies, and technical support to the commission.

Subd. 8. **Staff.** The commission may hire an executive director who serves in the unclassified service. The executive director may hire employees and consultants as authorized by the commission and may prescribe their duties. The attorney general shall provide legal services to the commission.

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

History: *1992 c 549 art 1 s 4; 1993 c 345 art 6 s 4; 1994 c 625 art 8 s 19; 1995 c 234 art 8 s 1,2*

62J.051 DISTRIBUTION OF HEALTH CARE TECHNOLOGY, FACILITIES, AND FUNCTIONS; PUBLIC FORUMS.

The commission may promote and facilitate an open, voluntary, nonregulatory, and public process for regional and statewide discussion regarding the appropriate distribution of health care technologies, facilities, and functions. The process must include the participation of consumers, employers and other group purchasers, providers, health plan companies, and the health care technology industry. The commission shall ensure opportunities for broad–based public input from other interested persons and organizations as well. The purpose of the process is to create an open public forum with the goal of facilitating collaboration for the distribution of a particular technology, facility, or function to achieve health reform goals. Participation in the forums is voluntary and agreements or distribution plans that may be recommended through this process are not mandatory or binding on any person or organization. The recommendations may be considered by the commissioner of health for purposes of the antitrust exception process under sections 62J.2911 to 62J.2921, and the process for reviewing major spending commitments under section 62J.17, but are not binding on the commissioner. The commission may develop criteria for selecting specific technologies, facilities, and functions for discussion and may establish procedures and ground rules for discussion and the development of recommended agreements or distribution plans. The commission may appoint advisory committees to facilitate discussion and planning and may request that regional coordinating boards serve as or convene regional public forums.

History: *1994 c 625 art 8 s 20*

62J.06 IMMUNITY FROM LIABILITY.

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

History: *1993 c 247 art 1 s 7; 1995 c 234 art 5 s 3*

62J.07 LEGISLATIVE OVERSIGHT COMMISSION.

Subdivision 1. **Legislative oversight.** The legislative commission on health care access reviews the activities of the commissioner of health, the state health care commission, and all other state agencies involved in the implementation and administration of this chapter, including efforts to obtain federal approval through waivers and other means.

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

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

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

History: *1992 c 549 art 1 s 5; 1993 c 247 art 4 s 11; 1994 c 625 art 8 s 72*

62J.09 REGIONAL COORDINATING BOARDS.

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

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

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

(3) provide technical assistance to parties interested in establishing or operating a community integrated service network or integrated service network within the region. This assistance must complement assistance provided by the commissioner under section 62N.23;

(4) advise the commissioner on public health goals, taking into consideration the relevant portions of the community health service plans, plans required by the Minnesota comprehensive adult mental health act, the Minnesota comprehensive children's mental health act, and the community social service act plans developed by county boards or community health boards in the region under chapters 145A, 245, and 256E;

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

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

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

Subd. 2. **Membership.** (a) **Number of members.** Each regional coordinating board consists of 17 members as provided in this subdivision. A member may designate a represen-

tative to act as a member of the board in the member's absence. The governor shall appoint the chair of each regional board from among its members. The appointing authorities under each paragraph for which there is to be chosen more than one member shall consult prior to appointments being made to ensure that, to the extent possible, the board includes a representative from each county within the region.

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

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

(d) **Employer representatives.** Regional boards include three members representing employers in the region. Employer representatives are appointed by the Minnesota chamber of commerce from nominations provided by members of chambers of commerce in the region. At least one member must represent self–insured employers.

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

(f) **Public members.** Regional boards include three consumer members. One consumer member is elected by the community health boards in the region, with each community health board having one vote. One consumer member is elected by the legislative commission on health care access. One consumer member is appointed by the governor.

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

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

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

Subd. 3a. **Communication with health care commission.** The chairs of the regional coordinating boards shall meet with the chair and the executive director of the health care commission on a periodic basis, but no less than biennially.

Subd. 4. **Financial interests of members.** A member representing employers, consumers, or employee unions must not have any personal financial interest in the health care system except as an individual consumer of health care services. An employee who participates in the management of a health benefit plan may serve as a member representing employers or unions.

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. Technical assistance includes providing each regional board with timely information concerning action plans, enrollment data, and health care expenditures affecting the regional board's region.

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 pro-

vide staff support to the board, in order to assist the board in carrying out the duties assigned in this section.

Subd. 7. **Terms; compensation; removal; and vacancies.** Regional coordinating boards are governed by section 15.0575, except that members do not receive per diem payments.

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

History: *1992 c 549 art 1 s 6; 1992 c 603 s 28; 1993 c 247 art 1 s 8–10; 1993 c 345 art 3 s 6; art 6 s 5–8; 1994 c 625 art 3 s 22; art 8 s 21,22; art 8 s 3–7*

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: *1992 c 549 art 1 s 7; 1993 c 247 art 1 s 11; 1993 c 345 art 4 s 2,3; 1994 c 465 art 3 s 66*

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 organizations in the development of practice parameters;

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

(5) by consumers in making decisions about treatment;

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

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

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

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

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 or-

ganization 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; 1994 c 625 art 3 s 22; 1995 c 234 art 3 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.

Subdivision 1. **Purpose.** To ensure access to affordable health care services for all Minnesotans it is necessary to restrain the rate of growth in health care costs. An important factor believed to contribute to escalating costs may be the purchase of costly new medical equipment, major capital expenditures, and the addition of new specialized services. After spending limits are established under section 62J.04, providers, patients, and communities will have the opportunity to decide for themselves whether they can afford capital expenditures or new equipment or specialized services within the constraints of a spending limit. In this environment, the state's role in reviewing these spending commitments can be more limited. However, during the interim period until spending targets are established, it is important to prevent unrestrained major spending commitments that will contribute further to the escalation of health care costs and make future cost containment efforts more difficult. In addition, it is essential to protect against the possibility that the legislature's expression of its attempt to control health care costs may lead a provider to make major spending commitments before targets or other cost containment constraints are fully implemented because the provider recognizes that the spending commitment may not be considered appropriate, needed, or affordable within the context of a fixed budget for health care spending. Therefore, the legislature finds that a requirement for reporting health care expenditures is necessary.

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

(a) **Access.** "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.

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

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

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

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

(1) a detailed description of the major spending commitment, including the specific dollar amount of each expenditure, and its purpose;

(2) the date of the major spending commitment;

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

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

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

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

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

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

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

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

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

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 subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) **Review.** The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the Minnesota health care commission shall convene an expert review panel made up of persons with knowledge and expertise re-

garding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

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

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

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

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

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

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

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

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

(b) In addition to the exceptions listed in paragraph (a), the prospective review and approval process described in subdivision 6a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

History: *1992 c 549 art 1 s 8; 1993 c 345 art 6 s 9–11; 1995 c 234 art 8 s 8–10*

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

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

62J.212 PUBLIC HEALTH GOALS.

The commissioner shall establish specific public health goals including, but not limited to, increased delivery of prenatal care, improved birth outcomes, and expanded childhood immunizations. The commissioner shall consider the community public health goals and the input of the statewide advisory committee on community health in establishing the statewide goals.

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

62J.22 PARTICIPATION OF FEDERAL PROGRAMS.

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

History: *1992 c 549 art 1 s 11*

62J.23 PROVIDER CONFLICTS OF INTEREST.

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

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

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

Subd. 4. **Chapter 62N networks.** (a) The legislature finds that the formation and operation of integrated service networks and community integrated service networks will accomplish the purpose of the federal Medicare antikickback statute, which is to reduce the overutilization and overcharging that may result from inappropriate provider incentives. Accordingly, it is the public policy of the state of Minnesota to support the development of integrated service networks and community 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 community integrated service networks or to impose liability for arrangements between an integrated service network or a community integrated service network and its participating entities.

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

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

62J.25 MANDATORY MEDICARE ASSIGNMENT.

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

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

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

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

(e) This section does not apply to ambulance services as defined in section 144.801, subdivision 4.

History: *1992 c 549 art 1 s 13*

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

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 arrangement 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 or members designated by the commissioner. The commissioner or the commissioner's designee or designees 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 or designees 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; 1994 c 625 art 8 s 24*

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 individu-

als 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 commissioner 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 compliance 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*

INFORMATION CLEARINGHOUSE

62J.2930 INFORMATION CLEARINGHOUSE.

Subdivision 1. **Establishment.** The commissioner of health shall establish an information clearinghouse within the department of health to facilitate the ability of consumers, employers, providers, health plan companies, and others to obtain information on health reform activities in Minnesota. The commissioner shall make available through the clearinghouse updates on federal and state health reform activities, including information developed or collected by the department of health on cost containment or other research initiatives, the development of integrated service networks, and voluntary purchasing pools, action plans submitted by health plan companies, reports or recommendations of the health technology advisory committee and other entities on technology assessments, and reports or recommendations from other formal committees applicable to health reform activities. The clearinghouse shall also refer requestors to sources of further information or assistance. The clearinghouse is subject to chapter 13.

Subd. 2. **Information on health plan companies.** The information clearinghouse shall provide information on all health plan companies operating in a specific geographic area to consumers and purchasers who request it.

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

(1) assist enrollees in understanding their rights;

(2) explain and assist in the use of all available complaint systems, including internal complaint systems within health carriers, community integrated service networks, integrated service networks, and the departments of health and commerce;

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

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

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

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

(1) provide legal services to consumers;

(2) represent a consumer or enrollee; or

(3) serve as an advocate for consumers in disputes with health plan companies.

Nothing in this subdivision shall interfere with the ombudsman program established under section 256B.031, subdivision 6, or other existing ombudsman programs.

Subd. 4. **Coordination.** To the extent possible, the commissioner shall coordinate the activities of the clearinghouse with the activities of the Minnesota health data institute.

History: *1995 c 234 art 5 s 5*

DATA COLLECTION AND RESEARCH INITIATIVES

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

62J.301 RESEARCH AND DATA INITIATIVES.

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

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

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

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

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

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

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

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

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

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

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

(7) participate as a partner or sponsor of private sector initiatives that promote publicly disseminated applied research on health care delivery, outcomes, costs, quality, and management.

Subd. 4. **Information to be collected.** (a) The data collected may include health outcomes data, patient functional status, and health status. The data collected may include information necessary to measure and make adjustments for differences in the severity of patient condition across different health care providers, and may include data obtained directly from the patient or from patient medical records, as provided in section 62J.321, subdivision 1.

(b) The commissioner may:

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

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

(c) For purposes of estimating total health care spending and forecasting rates of growth in health care spending, the commissioner may collect from health care providers data on patient revenues and health care spending during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers and group purchasers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

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

History: *1995 c 234 art 5 s 6*

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

62J.311 ANALYSIS AND USE OF DATA.

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

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

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

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

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

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

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

Subd. 2. **Criteria for data and research initiatives.** (a) Data and research initiatives by the commissioner, pursuant to sections 62J.301 to 62J.42, must:

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

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

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

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

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

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

(b) Data and research initiatives related to public sector health care programs must:

(1) assist the state's current health care financing and delivery programs to deliver and purchase health care in a manner that promotes improvements in health care efficiency and effectiveness;

(2) assist the state in its public health activities, including the analysis of disease prevalence and trends and the development of public health responses;

(3) assist the state in developing and refining its overall health policy, including policy related to health care costs, quality, and access; and

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

History: *1995 c 234 art 5 s 7*

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

62J.321 DATA COLLECTION AND PROCESSING PROCEDURES.

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

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

(c) The commissioner shall require all health care providers, group purchasers, and state agencies to use a standard patient identifier and a standard identifier for providers and health plan companies when reporting data under this chapter. The commissioner must encrypt patient identifiers to prevent identification of individual patients and to enable release of otherwise private data to researchers, providers, and group purchasers in a manner consistent with chapter 13 and sections 62J.55 and 144.335. This encryption must ensure that any data released must be in a form that makes it impossible to identify individual patients.

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

Subd. 3. **Data collection and review.** Data collection must continue for a sufficient time to permit: adequate analysis by researchers and appropriate providers, including providers who will be impacted by the data; feedback to providers; monitoring for changes in practice patterns; and the data and research criteria of section 62J.311, subdivision 2, to be fulfilled.

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

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

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

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

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

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

(e) Notwithstanding paragraph (a), the commissioner may publish nonpublic or private data collected pursuant to sections 62J.301 to 62J.42 on health care costs and spending, quality and outcomes, and utilization for health care institutions, individual health care professionals and groups of health care professionals, group purchasers, and integrated service networks, with a description of the methodology used for analysis. The commissioner may not make public any patient identifying information except as specified in law. The commissioner shall not reveal the name of an institution, group of professionals, individual health care professional, group purchaser, or integrated service network until after the institution, group of professionals, individual health care professional, group purchaser, or integrated service network has had 21 days to review the data and comment. The commissioner shall include comments received in the release of the data.

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

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

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

Subd. 8. **Contracts and grants.** To carry out the duties assigned in sections 62J.301 to 62J.42, the commissioner may contract with or provide grants to private sector entities. Any contract or grant must require the private sector entity to maintain the data which it receives according to the statutory provisions applicable to the data.

History: *1995 c 234 art 5 s 8*

62J.322 PROVIDER INFORMATION PILOT STUDY.

The commissioner shall develop a pilot study to collect comparative data from health care providers on opportunities and barriers to the provision of quality, cost–effective health care. The provider information pilot study shall include providers in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. Health plan companies and group purchasers shall provide to the commissioner providers' names, health plan assignment, and other appropriate data necessary for the commissioner to conduct the study. The provider information pilot study shall examine factors that increase and hinder access to the provision of quality, cost–effective health care. The study may examine:

(1) administrative barriers and facilitators;

(2) time spent obtaining permission for appropriate and necessary treatments;

(3) latitude to order appropriate and necessary tests, pharmaceuticals, and referrals to specialty providers;

(4) assistance available for decreasing administrative and other routine paperwork activities;

(5) continuing education opportunities provided;

(6) access to readily available information on diagnoses, diseases, outcomes, and new technologies;

(7) continuous quality improvement activities;

(8) inclusion in administrative decision making;

(9) access to social services and other services that facilitate continuity of care;

(10) economic incentives and disincentives;

(11) peer review procedures; and

(12) the prerogative to address public health needs.

In selecting additional data for collection, the commissioner shall consider the: (i) statistical validity of the data; (ii) public need for the data; (iii) estimated expense of collecting and reporting the data; and (iv) usefulness of the data to identify barriers and opportunities to improve quality care provision within health plan companies.

History: *1995 c 234 art 5 s 9*

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

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

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

62J.37 COST CONTAINMENT DATA FROM INTEGRATED SERVICE NETWORKS.

The commissioner shall require integrated service networks operating under section 62N.06, subdivision 1, to submit data on health care spending and revenue for calendar year 1996 by April 1, 1997. Each April 1 thereafter, integrated service networks shall submit to the commissioner data on health care spending and revenue for the preceding calendar year. The data must be provided in the form specified by the commissioner. To the extent that an

integrated service network is operated by a group purchaser under section 62N.06, subdivision 2, the integrated service network is exempt from this section and the group purchaser must provide data on the integrated service network under section 62J.38.

History: *1993 c 345 art 3 s 9; 1995 c 234 art 5 s 10*

62J.38 COST CONTAINMENT DATA FROM GROUP PURCHASERS.

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

(b) The commissioner shall require each group purchaser to submit data on revenue, expenses, and member months, as applicable. Revenue data must distinguish between premium revenue and revenue from other sources and must also include information on the amount of revenue in reserves and changes in reserves. Expenditure data, including raw data from claims, may be provided separately for the following categories or for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs.

(c) The commissioner may collect information on:

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

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

(3) information on health care services not provided through health plan companies, including information on prices, costs, expenditures, and utilization.

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

History: *1993 c 345 art 3 s 10; 1994 c 625 art 8 s 28; 1995 c 234 art 5 s 11*

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

(a) All state departments or agencies that administer one or more health care programs shall provide to the commissioner of health any additional data on the health care programs they administer that is requested by the commissioner of health, including data in unaggregated form, for purposes of developing estimates of spending, setting spending limits, and monitoring actual spending. The data must be provided at the times and in the form specified by the commissioner of health.

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

History: *1993 c 345 art 3 s 11; 1995 c 234 art 5 s 12*

62J.41 DATA FROM PROVIDERS.

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

(1) the total number of patients served;

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

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

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

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

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

(7) revenue from research activities;

(8) revenue from educational activities;

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

(10) revenue from donations; and

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

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

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

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

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

History: *1993 c 345 art 3 s 12; 1994 c 625 art 8 s 29; 1995 c 234 art 5 s 13,14*

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

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

History: *1993 c 345 art 3 s 13*

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

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

62J.451 MINNESOTA HEALTH DATA INSTITUTE.

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

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

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

(a) "Analysis" means the identification of selected data elements, a description of the methodology used to select or analyze those data elements, and any other commentary, con-

clusions, or other descriptive material that the health data institute determines is appropriately included, all of which is undertaken by the health data institute for one or more of the purposes or objectives set forth in subdivisions 1 and 3, or by other authorized researchers pursuant to section 62J.452, subdivision 6.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 5. **Health care electronic data interchange system.** (a) The health data institute shall establish an electronic data interchange system that electronically transmits, collects, archives, and provides users of data with the data necessary for their specific interests, in order to promote a high quality, cost–effective, consumer–responsive health care system. This public–private information system shall be developed to make health care claims processing and financial settlement transactions more efficient and to provide an efficient, unobtrusive method for meeting the shared electronic data interchange needs of consumers, group purchasers, providers, and the state.

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

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

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

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

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

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

(1) relevance to consumers and purchasers;

(2) prevalence of conditions;

(3) costs related to diagnosis and treatment;

(4) demonstrated efficacy of treatments;

(5) evidence of variability in management;

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

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

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

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

(1) accessibility;

(2) appropriateness;

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

(4) efficiency.

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

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

Subd. 6b. **Consumer surveys.** (a) The health data institute shall develop and implement a mechanism for collecting comparative data on consumer perceptions of the health care system, including consumer satisfaction, through adoption of a standard consumer survey. This survey shall include enrollees in community integrated service networks, integrated service networks, health maintenance organizations, preferred provider organizations, indemnity insurance plans, public programs, and other health plan companies. The health data institute, in consultation with the health care commission, shall determine a mechanism for the inclusion of the uninsured. This consumer survey may be conducted every two years. A focused survey may be conducted on the off years. Health plan companies and group purchasers shall provide to the health data institute roster data as defined in subdivision 2, including the names, addresses, and telephone numbers of enrollees and former enrollees and other data necessary for the completion of this survey. This roster data provided by the health plan companies and group purchasers is classified as provided under section 62J.452. The health data institute may analyze and prepare findings from the raw, unaggregated data, and the findings from this survey may be included in the health plan company performance reports specified in subdivision 6a, and in other reports developed and disseminated by the health data institute and the commissioner. The raw, unaggregated data is classified as provided under section

62J.452, and may be made available by the health data institute to the extent permitted under section 62J.452. The health data institute shall provide raw, unaggregated data to the commissioner. The survey may include information on the following subjects:

(1) enrollees' overall satisfaction with their health care plan;

(2) consumers' perception of access to emergency, urgent, routine, and preventive care, including locations, hours, waiting times, and access to care when needed;

(3) premiums and costs;

(4) technical competence of providers;

(5) communication, courtesy, respect, reassurance, and support;

(6) choice and continuity of providers;

(7) continuity of care;

(8) outcomes of care;

(9) services offered by the plan, including range of services, coverage for preventive and routine services, and coverage for illness and hospitalization;

(10) availability of information; and

(11) paperwork.

(b) The health data institute shall appoint a consumer advisory group which shall consist of 13 individuals, representing enrollees from public and private health plan companies and programs and two uninsured consumers, to advise the health data institute on issues of concern to consumers. The advisory group must have at least one member from each regional coordinating board region of the state. The advisory group expires June 30, 1996.

Subd. 6c. **Provider organization performance measurement.** As part of the performance measurement plan specified in subdivision 6, the health data institute shall develop a mechanism to assess the performance of hospitals and other provider organizations, and to disseminate this information to consumers, purchasers, policymakers, and other interested parties, consistent with the data policies specified in section 62J.452. Data to be collected may include structural characteristics including staff–mix and nurse–patient ratios. In selecting additional data for collection, the health data institute may consider:

(1) feasibility and statistical validity of the indicator;

(2) purchaser and public demand for the indicator;

(3) estimated expense of collecting and reporting the indicator; and

(4) usefulness of the indicator for internal improvement purposes.

Subd. 7. **Dissemination of reports; other information.** (a) The health data institute shall establish a mechanism for the dissemination of reports and other information to consumers, group purchasers, health plan companies, providers, and the state. When applicable, the health data institute shall coordinate its dissemination of information responsibilities with those of the commissioner, to the extent administratively efficient and effective.

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

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

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

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

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

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

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

Subd. 9. **Board of directors.** The health data institute is governed by a 20–member board of directors consisting of the following members:

(1) two representatives of hospitals appointed by the Minnesota Hospital and Health Care Partnership, to reflect a mix of urban and rural institutions;

(2) four representatives of health carriers, two appointed by the Minnesota council of health maintenance organizations, one appointed by Blue Cross and Blue Shield of Minnesota, and one appointed by the Insurance Federation of Minnesota;

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

(4) five group purchaser representatives appointed by the Minnesota consortium of health care purchasers to reflect a mix of urban and rural, large and small, and self–insured purchasers;

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

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

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

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

Subd. 10. **Terms; compensation; removal; and vacancies.** The board is governed by section 15.0575.

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

Subd. 12. **Staff.** The board may hire an executive director. The executive director and other health data institute staff are not state employees but are covered by section 3.736. The attorney general shall provide legal services to the board.

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

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

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

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

History: *1995 c 234 art 5 s 15; 1996 c 440 art 1 s 19–21*

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

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 4. **Analysis to be made public by the health data institute.** (a) Notwithstanding the classification under subdivision 2 or other provision of state law of data included or used in an analysis, the health data institute may make public data in an analysis pursuant to this subdivision and subdivision 5. Such analysis may include industry participant identifying

data but must not include patient identifying data. In making its determination as to whether to make an analysis or the data used in the analysis public, the health data institute shall consider and determine, in accordance with policies and criteria developed by the health data institute, that the data and analysis are sufficiently accurate, complete, reliable, valid, and as appropriate, case-mixed and severity adjusted, and statistically and clinically significant.

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

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

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

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

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

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

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

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

(1) the parties involved;

(2) the dates of the hearing; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(b) Data created or generated by or in the custody of an industry participant is subject to the privacy protections applicable to the data, including, but not limited to, chapter 13 with respect to state agencies and political subdivisions, the Minnesota insurance fair information reporting act with respect to industry participants subject to it, and section 144.335, with respect to providers and other industry participants subject to such section.

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

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

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

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

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

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

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

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

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

History: *1995 c 234 art 5 s 16*

62J.46 MONITORING AND REPORTS.

Subdivision 1. **Long-term care costs.** The commissioner, 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 legisla-

ture 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*

62J.47 MORATORIUM ON MERGERS OR ACQUISITIONS BY HEALTH CARRIERS.

Subdivision 1. **Definitions.** For purposes of this section, "health carrier" has the meaning given in section 62A.011, subdivision 2.

Subd. 2. **Restrictions.** Until July 1, 1996, the following health carriers are prohibited from merging with, or acquiring, directly or indirectly, any other health carrier:

(1) a health carrier whose number of enrollees residing in the state in the previous calendar year exceeds five percent of the total number of insured persons in that year residing in the state of Minnesota; and

(2) a health carrier whose number of enrollees residing in the seven–county metropolitan area in the previous calendar year exceeds ten percent of the total number of insured persons in that year residing in the seven–county metropolitan area.

Subd. 3. **Enforcement.** The district court in Ramsey county has jurisdiction to enjoin an alleged violation of subdivision 2. The attorney general may bring an action to enjoin an alleged violation. The commissioner of health or commerce shall not issue or renew a license or certificate of authority to any health carrier in violation of subdivision 2.

Subd. 4. **Exceptions.** This section does not apply to:

(1) any merger or direct or indirect acquisition approved by the commissioner that is intended to assure continuous coverage for enrollees and avoid liquidation or insolvency under chapter 60B;

(2) any merger or direct or indirect acquisition that develops pursuant to a letter of intent, memorandum of understanding, or other agreement signed before March 17, 1994;

(3) any merger or direct or indirect acquisition that develops pursuant to an affiliation for which a letter of intent, memorandum of understanding, or other agreement was signed before March 17, 1994; or

(4) any merger or direct or indirect acquisition of health carriers that are related organizations, as defined in section 317A.011, subdivision 18, as of March 17, 1994.

History: *1994 c 625 art 8 s 31*

62J.48 CRITERIA FOR REIMBURSEMENT.

All ambulance services licensed under section 144.802 are eligible for reimbursement under health plan companies. The commissioner shall require health plan companies to adopt the following reimbursement policies.

(1) All scheduled or prearranged air and ground ambulance transports must be reimbursed if requested by an attending physician or nurse, and, if the person is an enrollee in a health plan company, if approved by a designated representative of a health plan company who is immediately available on a 24–hour basis. The designated representative must be a registered nurse or a physician assistant with at least three years of critical care or trauma experience, or a licensed physician.

(2) Reimbursement must be provided for all emergency ambulance calls in which a patient is transported or medical treatment rendered.

(3) Special transportation services must not be billed or reimbursed if the patient needs medical attention immediately before transportation.

History: *1994 c 625 art 4 s 1; 1995 c 234 art 8 s 11*

HEALTH CARE ADMINISTRATIVE SIMPLIFICATION ACT OF 1994

62J.50 CITATION AND PURPOSE.

Subdivision 1. **Citation.** Sections 62J.50 to 62J.61 may be cited as the Minnesota health care administrative simplification act of 1994.

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

History: *1994 c 625 art 9 s 1*

62J.51 DEFINITIONS.

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

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

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

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

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

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

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

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

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

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

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

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

Subd. 9. **Eligibility transaction set (ANSI ASC X12 270/271).** "Eligibility transaction set (ANSI ASC X12 270/271)" means the transaction format developed and approved for

implementation in February 1993, and used by providers to request and receive coverage information on the member or insured.

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

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

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

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

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

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

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

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

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

Subd. 19. **Uniform dental billing form.** "Uniform dental billing form" means the 1990 uniform dental claim form developed by the American Dental Association.

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

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

History: *1994 c 625 art 9 s 2; 1996 c 440 art 1 s 22–25*

62J.52 ESTABLISHMENT OF UNIFORM BILLING FORMS.

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

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

(c) Services to be billed using the uniform billing form HCFA 1450 include: institutional inpatient hospital services and distinct units in the hospital such as psychiatric unit services, physical therapy unit services, swing bed (SNF) services, inpatient state psychiatric hospital services, inpatient skilled nursing facility services, home health services (Medicare part A), and hospice services; ancillary services, where benefits are exhausted or patient has no Medicare part A, from hospitals, state psychiatric hospitals, skilled nursing facilities, and home health (Medicare part B); and institutional owned or operated outpatient services such as hospital outpatient services, including ambulatory surgical center services, hospital referred laboratory services, hospital–based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, including infusion therapy, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient

rehabilitation facilities (ORF), rural health clinics, community mental health centers, and any other health care provider certified by the Medicare program to use this form.

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

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

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

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

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

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

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

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

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

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

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

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

History: *1994 c 625 art 9 s 3*

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

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

History: *1994 c 625 art 9 s 4*

62J.54 IDENTIFICATION AND IMPLEMENTATION OF UNIQUE IDENTIFIERS.

Subdivision 1. **Unique identification number for health care provider organizations.** (a) On and after January 1, 1998, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify health care provider organizations, except as provided in paragraph (e).

(b) The first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration shall be used as the unique identification number for health care provider organizations.

(c) Provider organizations required to have a national provider identifier are:

(1) hospitals licensed under chapter 144;

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

(3) subacute care facilities;

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

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

(6) ambulance services licensed under chapter 144; and

(7) special transportation services certified under chapter 174.

Provider organizations shall obtain a national provider identifier from the federal Health Care Financing Administration using the federal Health Care Financing Administration's prescribed process.

(d) Only the unique health care provider organization identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the Medicaid Management Information System or the national provider identifier maintained by the federal Health Care Financing Administration.

(f) The commissioner of health may become a subscriber to the federal Health Care Financing Administration's national provider system to implement this subdivision.

Subd. 2. **Unique identification number for individual health care providers.** (a) On and after January 1, 1998, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify an individual health care provider, except as provided in paragraph (e).

(b) The first eight digits of the national provider identifier maintained by the federal Health Care Financing Administration's national provider system shall be used as the unique identification number for individual health care providers.

(c) Individual providers required to have a national provider identifier are:

(1) physicians licensed under chapter 147;

(2) dentists licensed under chapter 150A;

(3) chiropractors licensed under chapter 148;

(4) podiatrists licensed under chapter 153;

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

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

(7) doctors of optometry licensed under section 148.57;

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

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

Providers shall obtain a national provider identifier from the federal Health Care Financing Administration using the Health Care Financing Administration's prescribed process.

(d) Only the unique individual health care provider identifier shall be used for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(e) The state and federal health care programs administered by the department of human services shall use the unique identification number assigned to health care providers for implementation of the Medicaid Management Information System or the national provider identifier maintained by the federal Health Care Financing Administration.

(f) The commissioner of health may become a subscriber to the federal Health Care Financing Administration's national provider system to implement this subdivision.

Subd. 3. **Unique identification number for group purchasers.** (a) On and after January 1, 1998, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify group purchasers.

(b) The payer identification number assigned for the federal Health Care Financing Administration's PAYERID system shall be used as the unique identification number for group purchasers.

(c) Group purchasers shall obtain a payer identifier number from the federal Health Care Financing Administration using the Health Care Financing Administration's prescribed process.

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

(e) The commissioner of health may become a registry user to the federal Health Care Financing Administration's PAYERID system to implement this subdivision.

Subd. 4. **Unique patient identification number.** (a) On and after January 1, 1998, all group purchasers and health care providers in Minnesota shall use a unique identification number to identify each patient who receives health care services in Minnesota, except as provided in paragraph (e).

(b) Except as provided in paragraph (d), following the recommendation of the workgroup for electronic data interchange, the social security number of the patient shall be used as the unique patient identification number.

(c) The unique patient identification number shall be used by group purchasers and health care providers for purposes of submitting and receiving claims, and in conjunction with other data collection and reporting functions.

(d) The commissioner shall develop an alternate numbering system for patients who do not have or refuse to provide a social security number. This provision does not require that patients provide their social security numbers and does not require group purchasers or providers to demand that patients provide their social security numbers. Group purchasers and health care providers shall establish procedures to notify patients that they can elect not to have their social security number used as the unique patient identification number.

(e) The state and federal health care programs administered by the department of human services shall use the unique person master index (PMI) identification number assigned to clients participating in programs administered by the department of human services.

History: *1994 c 625 art 9 s 5; 1995 c 234 art 5 s 17; 1996 c 440 art 1 s 26–28*

62J.55 PRIVACY OF UNIQUE IDENTIFIERS.

(a) When the unique identifiers specified in section 62J.54 are used for data collection purposes, the identifiers must be encrypted, as required in section 62J.321, subdivision 1. Encryption must follow encryption standards set by the National Bureau of Standards and approved by the American National Standards Institute as ANSIX3. 92–1982/R 1987 to protect the confidentiality of the data. Social security numbers must not be maintained in unen-

crypted form in the database, and the data must never be released in a form that would allow for the identification of individuals. The encryption algorithm and hardware used must not use clipper chip technology.

(b) Providers and group purchasers shall treat medical records, including the social security number if it is used as a unique patient identifier, in accordance with section 144.335. The social security number may be disclosed by providers and group purchasers to the commissioner as necessary to allow performance of those duties set forth in section 144.05.

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

62J.56 IMPLEMENTATION OF ELECTRONIC DATA INTERCHANGE STANDARDS.

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

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

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

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

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

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

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

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

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

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

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

(b) The commissioner shall promote the development of implementation guides among health care participants for those business transaction types for which implementation guides are not available, to allow providers and group purchasers to implement electronic data interchange. In promoting the development of these implementation guides, the commissioner shall review the work done by the American Hospital Association through the na-

tional Uniform Billing Committee and its state representative organization; the American Medical Association through the uniform claim task force; the American Dental Association; the National Council of Prescription Drug Programs; and the Workgroup for Electronic Data Interchange.

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

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

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

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

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

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

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

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

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

History: *1994 c 625 art 9 s 8*

62J.58 IMPLEMENTATION OF STANDARD TRANSACTION SETS.

Subdivision 1. **Claims payment.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I industry participants and all category II industry participants, except pharmacists, shall be able to submit or accept, as appropriate, the ANSI ASC X12 835 health care claim payment/advice transaction set (draft standard for trial use version/release 3051) for electronic submission of payment information to health care providers.

Subd. 2. **Claims submission.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 837 health care claim transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health care claim information.

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

Subd. 3. **Enrollment information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section

62J.56, subdivision 3, all category I and category II industry participants, excluding pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 834 health care enrollment transaction set (draft standard for trial use version/release 3051) for the electronic transfer of enrollment and health benefit information.

Subd. 4. **Eligibility information.** Six months from the date the commissioner formally recommends the use of guides to implement core transaction sets pursuant to section 62J.56, subdivision 3, all category I and category II industry participants, except pharmacists, shall be able to accept or submit, as appropriate, the ANSI ASC X12 270/271 health care eligibility transaction set (draft standard for trial use version/release 3051) for the electronic transfer of health benefit eligibility information.

Subd. 5. **Applicability.** This section does not require a group purchaser, health care provider, or employer to use electronic data interchange or to have the capability to do so. This section applies only to the extent that a group purchaser, health care provider, or employer chooses to use electronic data interchange.

History: *1994 c 625 art 9 s 9; 1995 c 234 art 5 s 19; 1996 c 440 art 1 s 30*

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

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

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

History: *1994 c 625 art 9 s 10*

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

Subdivision 1. **Minnesota health care identification card.** All individuals with health care coverage shall be issued health care identification cards by group purchasers as of January 1, 1998. The health care identification cards shall comply with the standards prescribed in this section.

Subd. 2. **General characteristics.** (a) The Minnesota health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional.

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

(c) Standardized labels are required next to human readable data elements. The card issuer may decide the location of the standardized label relative to the data element.

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

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be the card's front background. No standard label is required for this data element;

(2) claim submission number. The standardized label for this element is "Clm Subm #";

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

(4) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last

name, optional space and name suffix. The standardized label for this data element is "Name";

(5) account number(s), which is any other number, such as a group number, if required for part of the identification or claims process. The standardized label for this data element is "Account";

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

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

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

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

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

(2) telephone number(s) and name(s); which are the telephone number(s) and name(s) of the following contact(s) with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the card for health maintenance organizations and integrated service networks:

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

(2) telephone number to call to appeal to the commissioner of health. There is no standard label required for this information.

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

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

History: *1994 c 625 art 9 s 11; 1996 c 440 art 1 s 31,32*

62J.61 RULEMAKING; IMPLEMENTATION.

The commissioner of health is exempt from rulemaking in implementing sections 62J.50 to 62J.54, subdivision 3, and 62J.56 to 62J.59. The commissioner shall publish proposed rules in the State Register. Interested parties have 30 days to comment on the proposed rules. After the commissioner has considered all comments, the commissioner shall publish the final rules in the State Register 30 days before they are to take effect. The commissioner may use emergency and permanent rulemaking to implement the remainder of this article. The commissioner shall not adopt any rules requiring patients to provide their social security numbers unless and until federal laws are modified to allow or require such action nor shall the commissioner adopt rules which allow medical records, claims, or other treatment or clinical data to be included on the health care identification card, except as specifically pro-

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

History: *1994 c 625 art 9 s 12*

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

SENIOR DRUG DISCOUNT PROGRAM

62J.66 DEFINITIONS.

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

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

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

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

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

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

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

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

History: *1995 c 234 art 6 s 1*

62J.68 SENIOR DRUG DISCOUNT PROGRAM.

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

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

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

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

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

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

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

(3) pay administrative fees established under subdivision 7.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

January 15, 1996, and recommendations for program changes to the legislature by January 15, 1997.

History: *1995 c 234 art 6 s 2*

MEDICAL EDUCATION AND RESEARCH TRUST FUND

62J.69 MEDICAL EDUCATION AND RESEARCH TRUST FUND.

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

(a) "Medical education" means the accredited clinical training of physicians (medical students and residents), dentists, advanced practice nurses (clinical nurse specialist, certified registered nurse anesthetists, nurse practitioners, and certified nurse midwives), and physician assistants.

(b) "Clinical training" means accredited training that occurs in both inpatient and ambulatory care settings.

(c) "Trainee" means students involved in an accredited clinical training program for medical education as defined in paragraph (a).

(d) "Health care research" means approved clinical, outcomes, and health services investigations that are funded by patient out–of–pocket expenses or a third–party payer.

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

(f) "Teaching institutions" means any hospital, medical center, clinic, or other organization that currently sponsors or conducts accredited medical education programs or clinical research in Minnesota.

Subd. 2. **Allocation and funding for medical education and research.** (a) The commissioner may establish a trust fund for the purposes of funding medical education and research activities in the state of Minnesota.

(b) By January 1, 1997, the commissioner may appoint an advisory committee to provide advice and oversight on the distribution of funds from the medical education and research trust fund. If a committee is appointed, the commissioner shall: (1) consider the interest of all stakeholders when selecting committee members; (2) select members that represent both urban and rural interest; and (3) select members that include ambulatory care as well as inpatient perspectives. The commissioner shall appoint to the advisory committee representatives of the following groups: medical researchers, public and private academic medical centers, managed care organizations, Blue Cross and Blue Shield of Minnesota, commercial carriers, Minnesota Medical Association, Minnesota Nurses Association, medical product manufacturers, employers, and other relevant stakeholders, including consumers. The advisory committee is governed by section 15.059, for membership terms and removal of members and will sunset on June 30, 1999.

(c) Eligible applicants for funds are accredited medical education teaching institutions, consortia, and programs. Applications must be received by September 30 of each year for distribution by January 1 of the following year. An application for funds must include the following:

(1) the official name and address of the institution, facility, or program that is applying for funding;

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

(3) the total number, type, and specialty orientation of eligible trainees in each accredited medical education program applying for funds;

(4) audited clinical training costs per trainee for each medical education program;

(5) a description of current sources of funding for medical education costs including a description and dollar amount of all state and federal financial support;

(6) other revenue received for the purposes of clinical training;

(7) a statement identifying unfunded costs; and

(8) other supporting information the commissioner, with advice from the advisory committee, determines is necessary for the equitable distribution of funds.

(d) The commissioner shall distribute medical education funds to all qualifying applicants based on the following basic criteria: (1) total medical education funds available; (2) total trainees in each eligible education program; and (3) the statewide average cost per trainee, by type of trainee, in each medical education program. Funds distributed shall not be used to displace current funding appropriations from federal or state sources.

(e) Medical education programs receiving funds from the trust fund must submit annual cost and program reports based on criteria established by the commissioner. The reports must include:

(1) the total number of eligible trainees in the program;

(2) the type of programs and residencies funded;

(3) the average cost per trainee and a detailed breakdown of the components of those costs;

(4) other state or federal appropriations received for the purposes of clinical training;

(5) other revenue received for the purposes of clinical training; and

(6) other information the commissioner, with advice from the advisory committee, deems appropriate to evaluate the effectiveness of the use of funds for clinical training.

The commissioner, with advice from the advisory committee, will provide an annual summary report to the legislature on program implementation due February 15 of each year.

(f) The commissioner is authorized to distribute funds made available through:

(1) voluntary contributions by employers or other entities;

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

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

(g) The advisory committee shall continue to study and make recommendations on:

(1) the funding of medical research consistent with work currently mandated by the legislature and under way at the department of health; and

(2) the costs and benefits associated with medical education and research.

History: *1996 c 451 art 4 s 1*