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Senate

State of Minnesota

S.F. No. 1005 - Adopted Persons Records Access

Author: Senator Ann Rest

Prepared by: Joan White, Senate Counsel (651/296-3814)

Date: March 14, 2005

Section 1 (144.218, subdivision 1) amends the Department of Health adoption birth records, by changing the status of the birth record under the data privacy act from "confidential" to "private data." Confidential data means data that is made not public by statute or federal law and is inaccessible to the individual subject of the data. Private data means data that is made by statute or federal law applicable to the data (a) not public, and (b) accessible to the individual subject of the data. This section also provides upon request the information contained in the original birth record to the adopted person who is the subject of the vital record if that person is at least 19 years old.

Section 2(144.218, subdivision 2) changes the certified copies of court findings and the order or decree of adoption, the certificate of adoption, or decree of intercountry adoption from confidential to private data under the data practices act, and allows the adopted person to receive the same upon request if the person is at least 19 years old.

Section 3 (259.83, subdivision 1) modifies what adoption services are provided and to whom. Under current law, the agency is required to provide services to adult genetic siblings if there is no known violation of the confidentiality of a birth parent or if the birth parent gives written consent. The bill strikes the language related to confidentiality and written consent, requires the agency, upon request, to provide services to any adult siblings, and requires adopted persons 19 years or older to be advised of any siblings. If the person was committed to the guardianship of the state due to a termination of parental rights and was not adopted, the person must be advised of other siblings who were adopted or were committed to the guardianship of the state and not adopted.

A new paragraph (b) allows a person age 19 or older who was adopted from a foreign country to receive copies of all documents and referral information from the agency, upon request. Birth parent

identities must be included consistent with the policies of the adopted person's country of origin. The agency is required to provide information about procedures for contacting birth parents.

Section 4(259.83, subdivision 3) applies to adoptive placements made on or after August 1, 1982. Current law specifies a process that must be followed if an adopted person requests that an agency give the adopted person the information on the their original birth record.

This process requires the agency supervising the adoptive placement to inform the birth parents of the adopted person's right at age 19 to request original birth record information and the birth parent's right to object to the release of that information by filing an affidavit of nondisclosure. Under current law, if a birth parent does not file an affidavit of nondisclosure before the adopted person reaches age 19, the agency will release the information to the adopted person who has requested it. If the birth parent has filed an affidavit of nondisclosure, an adopted person may petition the court for the release of the identifying information about a birth parent.

The amendment to this section clarifies that this process from current law remains in effect for all adopted placements made up until August 1, 2005, the effective date of this bill.

Section 5 (259.83, subdivision 3a) adds a new subdivision specifying a new procedure for the release of birth records and other information to adopted persons for all adoptive placements made on or after August 1, 2005. This new subdivision requires the agency responsible for or supervising the placement to obtain from the birth parents an affidavit attesting that the birth parents have been informed of the provisions in this section, which include:

(1) the right of the adopted person to receive a copy of the original birth record, and the last known address, birth date, and birth place of each birth parent, and all medical and social information from the birth parent history form;

(2) that each birth parent may state that parent's contact preference subject to the adopted person's rights under clause (1). The contact preference is direct contact, contact through an intermediary, or no contact at all. The birth parent may change the contact preference and time prior to the birth parent's death;

(3) that a birth parent who files a no contact preference understands that the agency will release the information under clause (1), and that indicating no contact does not preclude the adopted person from contacting the birth parent; and

(4) that if the birth parent does not file a contact preference before the adopted person reaches age 19, the agency will provide the adopted person with the information upon request.

Section 6 (259.89) significantly modifies the statute dealing with access to the original birth certificate by authorizing the Commissioner of Health to give adopted persons age 19 or older access to the person's original birth record information.

The bill changes the access to birth records as follows:

Subdivision 1 relates to the request for information. The new language applies to adoptions granted before August 1, 2005, and requires the Commissioner of Health to disclose the information contained in the original birth record unless there is an unrevoked affidavit of nondisclosure on file at the Department of Health. If there is an unrevoked affidavit of nondisclosure, the Commissioner of Health is required to notify the adopted person of the date of the filing of the affidavit.

Subdivision 2 provides that if a birth parent has filed an affidavit of nondisclosure, the adopted person may request the assistance of the Commissioner of Human Services in contacting the birth parent, notifying the birth parent of the adopted person's request for birth record information, and inquiring if the birth parent desires to revoke the affidavit of disclosure. This subdivision also strikes information that was to be provided to each parent, and adds language that lists what information must be provided to the adopted person after the attempt to contact the birth parent, which includes: the date the birth parent was contacted, the birth parent's response, and if the birth parent decided after being contacted to revoke the affidavit of nondisclosure, a copy of the signed and dated affidavit of disclosure. If the birth parent did not revoke the affidavit of nondisclosure, the birth parent must be advised of the right to file a consent to disclosure at any time with the Commissioner of Health.

Subdivision 3 strikes language that prevents the commissioner from disclosing information on the original birth record if either parent filed an unrevoked affidavit stating that the information should not be disclosed. New language allows the information to be disclosed if the Commissioner of Human Services certifies an inability to notify a parent who had filed an affidavit of nondisclosure or certifies that the parent is deceased.

Subdivision 4 strikes language related to the disclosure of information after notice, and adds language requiring the commissioner to release a copy of the original birth record pursuant to section 5 upon request of an adopted person 19 years or older for all adoptions granted on or after August 1, 2005.

Subdivision 5 of current law is stricken. Current law under this subdivision prohibited the disclosure of information if a deceased parent at any time prior to the death of the parent filed an unrevoked affidavit stating that the information should not be disclosed. The adopted person was required to petition the court for the disclosure of the original birth record.

Section 7 makes this bill effective August 1, 2005.

JW:rdr

Senators Rest, Ranum, Dille, Pappas and Neuville introduced--

S.F. No. 1005: Referred to the Committee on Judiciary.

A bill for an act

relating to adoption records; providing access to certain records by certain persons; providing for certain services; changing classification of certain data; amending Minnesota Statutes 2004, sections 144.218, subdivisions 1, 2; 259.83, subdivisions 1, 3, by adding a subdivision; 259.89.

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

Section 1. Minnesota Statutes 2004, section 144.218, subdivision 1, is amended to read:

Subdivision 1. [ADOPTION.] Upon receipt of a certified copy of an order, decree, or certificate of adoption, the state registrar shall register a replacement vital record in the new name of the adopted person. The original record of birth is ~~confidential pursuant to~~ private data on individuals as defined in section 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or section 144.2252. The information contained on the original birth record, except for the registration number, shall be provided on request to: (1) a parent who is named on the original birth record; and (2) the adopted person who is the subject of the vital record if that person is at least 19 years of age. Upon the receipt of a certified copy of a court order of annulment of adoption the state registrar shall restore the original vital record to its original place in the file.

Sec. 2. Minnesota Statutes 2004, section 144.218,

subdivision 2, is amended to read:

Subd. 2. [ADOPTION OF FOREIGN PERSONS.] In proceedings for the adoption of a person who was born in a foreign country, the court, upon evidence presented by the commissioner of human services from information secured at the port of entry or upon evidence from other reliable sources, may make findings of fact as to the date and place of birth and parentage. Upon receipt of certified copies of the court findings and the order or decree of adoption, a certificate of adoption, or a certified copy of a decree issued under section 259.60, the state registrar shall register a birth record in the new name of the adopted person. Notwithstanding section 259.61, the certified copies of the court findings and the order or decree of adoption, certificate of adoption, or decree issued under section 259.60 are ~~confidential, pursuant to~~ private data on individuals as defined in section 13.02, subdivision ~~3~~ 12, and shall not be disclosed except pursuant to court order or section 144.2252 or, on request, to the adopted person who is the subject of the adoption proceeding if that person is at least 19 years of age. The birth record shall state the place of birth as specifically as possible and that the vital record is not evidence of United States citizenship.

Sec. 3. Minnesota Statutes 2004, section 259.83, subdivision 1, is amended to read:

Subdivision 1. [SERVICES PROVIDED.] (a) Agencies shall provide assistance and counseling services upon receiving a request for current information from adoptive parents, birth parents, or adopted persons aged 19 years and over. The agency shall contact the other adult persons or the adoptive parents of a minor child in a personal and confidential manner to determine whether there is a desire to receive or share information or to have contact. If there is such a desire, the agency shall provide the services requested. The agency shall, on request, provide services to adult ~~genetic~~ siblings ~~if there is no known violation of the confidentiality of a birth parent or if the birth parent gives written consent~~. Adopted persons aged 19

years and over must be advised of any siblings, regardless of when the adoption took place. Persons aged 19 and over who, because of a termination of parental rights were committed to the guardianship of the commissioner of human services and were not adopted, must be advised of other siblings who were (1) adopted, or (2) committed to the guardianship of the commissioner and not adopted. The agency shall search for and offer services to other siblings. If a sibling was adopted through another agency, the agencies shall share necessary information and work together to locate the other sibling and offer services.

(b) A person aged 19 or over who was adopted from a foreign country shall, upon request, receive copies from the agency of all documents and referral information the person's adoptive parents received from the foreign country at the time of the adoption. Birth parent identities must be included consistent with the current policies of the child's country of origin. The agency shall provide information about procedures for contact with birth parents in the child's country of origin.

Sec. 4. Minnesota Statutes 2004, section 259.83, subdivision 3, is amended to read:

Subd. 3. [~~IDENTIFYING~~ BIRTH RECORD INFORMATION FROM AGENCY.] In adoptive placements made on and after August 1, 1982, and before August 1, 2005, the agency responsible for or supervising the placement shall obtain from the birth parents named on the original birth record an affidavit attesting to the following:

(a) that the birth parent has been informed of the right of the adopted person at the age specified in section 259.89 to request from the agency the name, last known address, birthdate and birthplace of the birth parents named on the adopted person's original birth record;

(b) that each birth parent may file in the agency record an affidavit objecting to the release of any or all of the information listed in clause (a) about that birth parent, and that parent only, to the adopted person;

(c) that if the birth parent does not file an affidavit objecting to release of information before the adopted person reaches the age specified in section 259.89, the agency will provide the adopted person with the information upon request;

(d) that notwithstanding the filing of an affidavit, the adopted person may petition the court according to section 259.61 for release of identifying information about a birth parent;

(e) that the birth parent shall then have the opportunity to present evidence to the court that nondisclosure of identifying information is of greater benefit to the birth parent than disclosure to the adopted person; and

(f) that any objection filed by the birth parent shall become invalid when withdrawn by the birth parent or when the birth parent dies. Upon receipt of a death record for the birth parent, the agency shall release the identifying information to the adopted person if requested.

Sec. 5. Minnesota Statutes 2004, section 259.83, is amended by adding a subdivision to read:

Subd. 3a. [BIRTH RECORD AND OTHER INFORMATION FROM AGENCY AND DEPARTMENT OF HEALTH.] In adoptive placements made on and after August 1, 2005, the agency responsible for or supervising the placement shall obtain from the birth parents named on the original birth record an affidavit attesting that the birth parent has been informed of the following:

(1) the right of the adopted person at the age specified in section 259.89 to receive a copy of the person's original birth record from the Department of Health, and to receive from the agency the name, last known address, birth date, and birth place of each birth parent named on the person's original birth certificate and all available medical and social information under section 259.43;

(2) that each birth parent may state that parent's contact preference subject to the adopted person's rights under clause (1). Contact preference must be direct contact, use of an intermediary for contact, or no contact at all. The birth

parent may submit a new contact preference statement and updated medical and social information any time prior to the birth parent's death. The contact preference statement must be filed with the agency. The agency shall send a copy to the Department of Health, Office of the State Registrar;

(3) that a birth parent who files a preference under clause (2) for no contact understands that the agency will release the information in clause (1). Indicating no contact does not preclude the adopted person from contacting the birth parent; and

(4) that if the birth parent does not file a preference under clause (2) for no contact before the adopted person reaches the age specified in section 259.89, the agency will provide the adopted person with the information upon request.

Sec. 6. Minnesota Statutes 2004, section 259.89, is amended to read:

259.89 [ACCESS TO ORIGINAL BIRTH RECORD INFORMATION.]

Subdivision 1. [REQUEST.] In all adoptions granted before August 1, 2005, an adopted person who is 19 years of age or over may request the commissioner of health to disclose the information on the adopted person's original birth record. The commissioner of health shall disclose the information contained on the original birth record unless there is an unrevoked affidavit of nondisclosure on file with the Department of Health. If only one parent has filed an unrevoked affidavit of nondisclosure, the commissioner of health shall disclose to the adopted person original birth record information on the other parent. If there is an unrevoked affidavit of nondisclosure, the commissioner of health shall, within five days of receipt of the request, notify the ~~commissioner of human services in writing of the request by the adopted person~~ petitioner in writing of the date of filing of the affidavit of nondisclosure.

Subd. 2. [SEARCH.] Upon receipt of the commissioner of health's notice of the date of filing the affidavit of nondisclosure, the adopted person may request the assistance of the commissioner of human services in contacting the birth

parent, notifying the birth parent of the adopted person's request for birth record information, and inquiring if the birth parent desires to revoke the affidavit of nondisclosure. Within six months after receiving notice of the request of the adopted person, the commissioner of human services shall make complete and reasonable efforts to notify each parent identified on the original birth record of the adopted person. The commissioner, the commissioner's agents, and licensed child-placing agencies may charge a reasonable fee to the adopted person for the cost of making a search pursuant to this subdivision. Every licensed child-placing agency in the state shall cooperate with the commissioner of human services in efforts to notify an identified parent. All communications under this subdivision are confidential pursuant to section 13.02, subdivision 3.

For purposes of this subdivision, "notify" means a personal and confidential contact with the birth parents named on the original birth record of the adopted person. The contact shall not be by mail and shall be by an employee or agent of the licensed child-placing agency which processed the pertinent adoption or some other licensed child-placing agency designated by the commissioner of human services. The contact shall be evidenced by filing with the commissioner of health an affidavit of notification executed by the person who notified ~~each~~ the parent certifying that ~~each parent~~ the adopted person was given the following information:

~~(a) The nature of the information requested by the adopted person;~~

~~(b) The date of the request of the adopted person;~~

~~(c) The right of the parent to file, within 30 days of receipt of the notice, an affidavit with the commissioner of health stating that the information on the original birth record should not be disclosed;~~

~~(d) The right of the parent to file a consent to disclosure with the commissioner of health at any time; and~~

~~(e) The effect of a failure of the parent to file either a consent to disclosure or an affidavit stating that the~~

~~information on the original birth record should not be disclosed.~~

(1) the date the birth parent was contacted;

(2) the birth parent's response; and

(3) if the birth parent decided to revoke the affidavit of nondisclosure, a copy of a signed and dated affidavit of disclosure. Upon receipt of the affidavit of disclosure, the commissioner of health shall release the original birth record to the adopted person.

If the birth parent does not revoke the affidavit of nondisclosure, the birth parent must be advised of the right to file a consent to disclosure with the commissioner of health at any time. The agency shall send a copy of the contact to the Department of Health, Office of the State Registrar.

Subd. 3. [FAILURE TO NOTIFY PARENT.] If the commissioner of human services certifies to the commissioner of health an inability to notify a parent ~~identified on the original birth record within six months, and if neither identified parent has at any time filed an unrevoked consent to disclosure with the commissioner of health, the information may be disclosed as follows:~~

~~(a) If the person was adopted prior to August 1, 1977, the person may petition the appropriate court for disclosure of the original birth record pursuant to section 259.61, and the court shall grant the petition if, after consideration of the interests of all known persons involved, the court determines that disclosure of the information would be of greater benefit than nondisclosure.~~

~~(b) If the person was adopted on or after August 1, 1977, the commissioner of health shall release the requested information to the adopted person.~~

~~If either parent identified on the birth record has at any time filed with the commissioner of health an unrevoked affidavit stating that the information on the original birth record should not be disclosed, the commissioner of health shall not disclose the information to the adopted person until the affidavit is revoked by the filing of a consent to disclosure by~~

~~that-parent~~ who had filed an affidavit of nondisclosure or certifies the parent is deceased, the commissioner of health shall release the original birth record to the adopted person.

Subd. 4. [RELEASE OF INFORMATION ~~AFTER-NOTICE~~; ADOPTIONS ON OR AFTER AUGUST 1, 2005.] ~~If,-within-six-months,-the-commissioner-of-human-services-certifies-to-the-commissioner-of-health-notification-of-each-parent-identified-on-the-original-birth-record-pursuant-to-subdivision-2,-the-commissioner-of-health-shall-disclose-the-information-requested-by-the-adopted-person-31-days-after-the-date-of-the-latest-notice-to-either-parent.--This-disclosure-will-occur-if,-at-any-time-during-the-31-days-both-of-the-parents-identified-on-the-original-birth-record-have-filed-a-consent-to-disclosure-with-the-commissioner-of-health-and-neither-consent-to-disclosure-has-been-revoked-by-the-subsequent-filing-by-a-parent-of-an-affidavit-stating-that-the-information-should-not-be-disclosed.--If-only-one-parent-has-filed-a-consent-to-disclosure-and-the-consent-has-not-been-revoked,-the-commissioner-of-health-shall-disclose,-to-the-adopted-person,-original-birth-record-information-on-the-consenting-parent-only.~~ For all adoptions granted on or after August 1, 2005, the commissioner of health shall, upon request of an adopted person aged 19 or over, release a copy of the original birth record pursuant to section 259.83, subdivision 3a.

Subd. 5. ~~[DEATH-OF-PARENT.]-Notwithstanding-the-provisions-of-subdivisions-3-and-4,-if-a-parent-named-on-the-original-birth-record-of-an-adopted-person-has-died,-and-at-any-time-prior-to-the-death-the-parent-has-filed-an-unrevoked-affidavit-with-the-commissioner-of-health-stating-that-the-information-on-the-original-birth-record-should-not-be-disclosed,-the-adopted-person-may-petition-the-court-of-original-jurisdiction-of-the-adoption-proceeding-for-disclosure-of-the-original-birth-record-pursuant-to-section-259.61.--The-court-shall-grant-the-petition-if,-after-consideration-of-the-interests-of-all-known-persons-involved,-the-court-determines-that-disclosure-of-the-information-would-be-of-greater-benefit-than-nondisclosure.~~

~~Subd.-6.~~ [DETERMINATION OF ELIGIBILITY FOR ENROLLMENT OR

MEMBERSHIP IN A FEDERALLY RECOGNIZED AMERICAN INDIAN TRIBE.] The state registrar shall provide a copy of an adopted person's original birth record to an authorized representative of a federally recognized American Indian tribe for the sole purpose of determining the adopted person's eligibility for enrollment or membership in the tribe.

Sec. 7. [EFFECTIVE DATE.]

Sections 1 to 6 are effective August 1, 2005.

Senator ..... moves to amend S.F. No. 1005 as follows:

Page 3, line 24, delete "August 1, 2005" and insert "January 1, 2006"

Page 4, line 20, delete "AND OTHER INFORMATION" and delete "AGENCY"

Page 4, line 21, delete "AND"

Page 4, line 22, delete "August 1, 2005" and insert "January 1, 2006"

Page 4, line 28, delete everything after "Health"

Page 4, delete lines 29 to 31

Page 4, line 32, delete everything before the semicolon

Page 5, line 4, delete everything after the first "agency" and insert a semicolon

Page 5, delete line 5

Page 5, line 7, delete "agency" and insert "Department of Health"

Page 5, line 19, delete "August 1, 2005" and insert "January 1, 2006"

Page 5, after line 32, insert:

"Subd. 1a. [AFFIDAVIT OF NONDISCLOSURE.] A birth parent may file an affidavit of nondisclosure regardless of the date of relinquishment. An affidavit of nondisclosure on file by January 1, 2006, must be honored."

Page 5, line 33, before "Upon" insert "(a)"

Page 6, line 15, before "For" insert "(b)"

Page 6, line 22, strike everything after "by" and insert "notifying"

Page 6, line 23, strike "of notification executed by the person who notified" and delete "the"

Page 6, line 24, strike "parent certifying that" and after " person" insert "of" and strike "was given"

Page 7, line 2, after the semicolon, insert "and"

Page 7, line 3, delete "; and" and insert a period

Page 7, line 4, delete "(3)" and insert "(c)"

Page 7, line 6, before the period, insert "must be filed with the Department of Health, Office of the State Registrar"

and before the comma, insert "and a notarized request from the adopted person"

Page 7, line 9, before "If" insert:

"(d)"

Page 7, line 12, delete everything after the period

Page 7, delete line 13

Page 8, line 5, delete "AUGUST 1, 2005" and insert "JANUARY 1, 2006"

Page 8, line 21, delete "August 1, 2005" and insert "January 1, 2006"

Page 9, line 8, delete "August 1, 2005" and insert "January 1, 2006"

Lutheran Social Service
for changing lives

March 22, 2005

MEMO

TO: The Chairs and Members of the Health and Human Service Committees of the Minnesota State Legislature

RE: LSS response to the events in Red Lake

Dear Chairs and Committee Members,

We are all saddened by the events in Red Lake. By way of response, LSS has offered to provide professional counseling and trauma support to the Red Lake tribal community in the wake of the school shooting. In the long-term, LSS has also offered to make grief support available for families and friends affected by the loss of loved ones and others who may need assistance. In addition, LSS is exploring with the tribal community whether financial support will be needed to assist families affected by this tragedy.

Melanie Josephson, LSS Disaster Services, and Greg Nelson, LSS Counseling Services, both national trainers on trauma support and disaster response, will be leading these efforts.

Sincerely,

Mark Peterson
President and CEO
Lutheran Social Service of Minnesota

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 1567 - Rural Pharmacy Grant Program

Author: Senator Gary W. Kubly

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 21, 2005

S.F. No. 1567 creates a rural pharmacy planning and transition grant program and extends the loan forgiveness program to pharmacists who agree to practice in a designated rural area.

Section 1 (144.1476) establishes the rural pharmacy grant program.

Subdivision 1 defines the following terms: "eligible rural community," "health care provider," "pharmacist," and "pharmacy."

Subdivision 2 requires the Commissioner of Health to establish a program to award grants to eligible rural communities or health care providers for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist. The applicant for a grant is required to develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. The strategic plan must consist of a needs assessment to determine what pharmacy services are needed and desired by the community, the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes, and an implementation plan. A grant may be used to implement transition projects to modify the type and extent of pharmacy services provided that reflects the needs of the community, to develop pharmacy practices that integrate pharmacy and existing health care provider facilities, or to establish a pharmacy provider cooperative or initiative that maintains local access to prescription medications and the skills of a pharmacist

Subdivision 3 states that any excess revenue collected by the Board of Pharmacy must be credited to a rural pharmacy grant account. Money in the account is appropriated to the

commissioner to issue grants under this program. No more than ten percent of the money appropriated may be used to pay for administrative expenses.

Subdivision 4 states that the commissioner shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues to determine which applicants should receive grants under this program. The committee shall take into account improving or maintaining access to prescription medications and the skills of a pharmacist; changes in service populations; the extent pharmacy needs are not being met by other providers in the area; the financial condition of the applicant; the integration of pharmacy services into existing health care providers; and community support.

Subdivision 5 requires the commissioner to establish an application deadline and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year. Each relevant community board has 30 days in which to review and comment to the commissioner on eligible applications. Each grant awarded may not exceed $50,000 a year and may not exceed a one-year term. Applicants may apply each year they are eligible. A grant may not be used to retire debt incurred with respect to any capital expenditure made prior to the date on which the project is initiated.

Subdivision 6 requires the grantees to submit annual evaluations. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the evaluation if requested by a grantee or the commissioner.

Sections 2 to 4 (144.1501) expand the loan forgiveness program to permit a licensed pharmacist who agrees to practice in a designated rural area to participate in the loan forgiveness program.

KC:ph

Senators Kubly, Rosen, Koering, Senjem and Lourey introduced--
S.F. No. 1567: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; providing for rural pharmacy preservation; establishing a rural pharmacy grant program; modifying the rural loan forgiveness program; appropriating money; amending Minnesota Statutes 2004, section 144.1501, subdivisions 1, 2, 3; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. [144.1476] [RURAL PHARMACY PLANNING AND TRANSITION GRANT PROGRAM.]

Subdivision 1. [DEFINITIONS.] (a) For the purposes of this section, the following definitions apply.

(b) "Eligible rural community" means:

(1) a Minnesota community that is located in a rural area, as defined in the federal Medicare regulations, Code of Federal Regulations, title 42, section 405.1041; or

(2) a Minnesota community that has a population of less than 10,000, according to the United States Bureau of Statistics, and that is outside the seven-county metropolitan area, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud.

(c) "Health care provider" means a hospital, clinic, pharmacy, long-term care institution, or other health care facility that is licensed, certified, or otherwise authorized by the laws of this state to provide health care.

(d) "Pharmacist" means an individual with a valid license

issued under chapter 151 to practice pharmacy.

(e) "Pharmacy" has the meaning given under section 151.01, subdivision 2.

Subd. 2. [GRANTS AUTHORIZED; ELIGIBILITY.] (a) The commissioner of health shall establish a program to award grants to eligible rural communities or health care providers in eligible rural communities for planning, establishing, keeping in operation, or providing health care services that preserve access to prescription medications and the skills of a pharmacist according to sections 151.01 to 151.40.

(b) To be eligible for a grant, an applicant must develop a strategic plan for preserving or enhancing access to prescription medications and the skills of a pharmacist. At a minimum, a strategic plan must consist of:

(1) a needs assessment to determine what pharmacy services are needed and desired by the community. The assessment must include interviews with or surveys of area and local health professionals, local community leaders, and public officials;

(2) an assessment of the feasibility of providing needed pharmacy services that identifies priorities and timelines for potential changes; and

(3) an implementation plan.

(c) A grant may be used by a recipient that has developed a strategic plan to implement transition projects to modify the type and extent of pharmacy services provided, in order to reflect the needs of the community. Grants may also be used by recipients:

(1) to develop pharmacy practices that integrate pharmacy and existing health care provider facilities; or

(2) to establish a pharmacy provider cooperative or initiatives that maintain local access to prescription medications and the skills of a pharmacist.

Subd. 3. [FUNDING.] Notwithstanding section 214.06, subdivision 1, any revenue collected by the Board of Pharmacy in excess of the board's expenditures shall be credited to a rural pharmacy grant account. Money in the account is appropriated to

the commissioner of health to issue grants under this section. No more than ten percent of the money appropriated may be used to pay for administrative expenses.

Subd. 4. [CONSIDERATION OF GRANTS.] In determining which applicants shall receive grants under this section, the commissioner of health shall appoint a committee comprised of members with experience and knowledge about rural pharmacy issues including two rural pharmacists with a community pharmacy background, two health care providers from rural communities, one representative from a statewide pharmacist organization, and one representative of the Board of Pharmacy. A representative of the commissioner may serve on the committee in an ex officio status. In determining who shall receive a grant, the committee shall take into account:

(1) improving or maintaining access to prescription medications and the skills of a pharmacist;

(2) changes in service populations;

(3) the extent community pharmacy needs are not currently met by other providers in the area;

(4) the financial condition of the applicant;

(5) the integration of pharmacy services into existing health care services; and

(6) community support.

Subd. 5. [ALLOCATION OF GRANTS.] (a) The commissioner shall establish a deadline for receiving applications and must make a final decision on the funding of each application within 60 days of the deadline. An applicant must apply no later than March 1 of each fiscal year for grants awarded for that fiscal year. Each relevant community board has 30 days in which to review and comment to the commissioner on eligible applications.

(b) Any grant awarded must not exceed $50,000 a year and may not exceed a one-year term.

(c) Applicants may apply to the program each year they are eligible.

(d) Project grants may not be used to retire debt incurred with respect to any capitol expenditure made prior to the date

on which the project is initiated.

Subd. 6. [EVALUATION.] The grant program shall be evaluated annually in reports by the recipients of the grants. An academic institution that has the expertise in evaluating rural pharmacy outcomes may participate in the program evaluation if asked by a recipient or the commissioner.

Sec. 2. Minnesota Statutes 2004, section 144.1501, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] (a) For purposes of this section, the following definitions apply.

(b) "Designated rural area" means:

(1) an area in Minnesota outside the counties of Anoka, Carver, Dakota, Hennepin, Ramsey, Scott, and Washington, excluding the cities of Duluth, Mankato, Moorhead, Rochester, and St. Cloud; or

(2) a municipal corporation, as defined under section 471.634, that is physically located, in whole or in part, in an area defined as a designated rural area under clause (1).

(c) "Emergency circumstances" means those conditions that make it impossible for the participant to fulfill the service commitment, including death, total and permanent disability, or temporary disability lasting more than two years.

(d) "Medical resident" means an individual participating in a medical residency in family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

(e) "Midlevel practitioner" means a nurse practitioner, nurse-midwife, nurse anesthetist, advanced clinical nurse specialist, or physician assistant.

(f) "Nurse" means an individual who has completed training and received all licensing or certification necessary to perform duties as a licensed practical nurse or registered nurse.

(g) "Nurse-midwife" means a registered nurse who has graduated from a program of study designed to prepare registered nurses for advanced practice as nurse-midwives.

(h) "Nurse practitioner" means a registered nurse who has graduated from a program of study designed to prepare registered

nurses for advanced practice as nurse practitioners.

(i) "Pharmacist" means an individual with a valid license issued under chapter 151 to practice pharmacy.

(j) "Physician" means an individual who is licensed to practice medicine in the areas of family practice, internal medicine, obstetrics and gynecology, pediatrics, or psychiatry.

~~(j)~~ (k) "Physician assistant" means a person registered under chapter 147A.

~~(k)~~ (l) "Qualified educational loan" means a government, commercial, or foundation loan for actual costs paid for tuition, reasonable education expenses, and reasonable living expenses related to the graduate or undergraduate education of a health care professional.

~~(l)~~ (m) "Underserved urban community" means a Minnesota urban area or population included in the list of designated primary medical care health professional shortage areas (HPSAs), medically underserved areas (MUAs), or medically underserved populations (MUPs) maintained and updated by the United States Department of Health and Human Services.

Sec. 3. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program for medical residents agreeing to practice in designated rural areas or underserved urban communities, for midlevel practitioners agreeing to practice in designated rural areas, ~~and~~ for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions, and for pharmacists who agree to practice in designated rural areas. Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 4. Minnesota Statutes 2004, section 144.1501, subdivision 3, is amended to read:

Subd. 3. [ELIGIBILITY.] (a) To be eligible to participate in the loan forgiveness program, an individual must:

(1) be a medical resident or a licensed pharmacist or be enrolled in a midlevel practitioner, registered nurse, or a licensed practical nurse training program; and

(2) submit an application to the commissioner of health.

(b) An applicant selected to participate must sign a contract to agree to serve a minimum three-year full-time service obligation according to subdivision 2, which shall begin no later than March 31 following completion of required training.

Sec. 5. [APPROPRIATION.]

$200,000 in fiscal year 2006 and $200,000 in fiscal year 2007 are appropriated from the health occupations licensing account in the special revenue fund to the commissioner of health for purposes of Minnesota Statutes, section 144.1476. This is a onetime appropriation.

Rural Pharmacy In Minnesota

Rural Pharmacists Provide:

✔**Local and convenient access to medications and drug therapy.**

✔**Needed patient education about health conditions, medication use and side effects.**

✔**Management of drug safety and drug safety issues.**

- *Twenty-five percent of the U.S. population lives in rural areas, many are elderly. With the exponential increase in elderly people taking life-preserving medications for chronic disorders, pharmacists in rural areas provide an essential service.*

✔**Drug therapy knowledge to rural hospitals, clinics and long-term care facilities.**

- *Many pharmacists in small towns provide nursing home patients with medications. In addition, federal law requires monthly pharmacists' review of residents' medications.*
- *In the hospitals in these small towns, pharmacists oversee distribution of inpatient medications.*
- *Often, rural hospitals and nursing homes count on the local community pharmacist to provide these services.*

✔**Pharmacists are one of a limited number of health care providers serving in rural communities.**

- *The trusted expertise of pharmacists in medication management for patients cannot be provided through online or mail delivery of medications.*

✔**Access to over-the-counter medications, medical equipment and supplies, and flu and pneumococcal immunizations**

✔**Care for veterinary patients.**

Minnesota Rural Pharmacy Statistics:

There are 1,502 pharmacies in Minnesota; 641 of them (44%) are in rural Minnesota.

Rural Minnesota has lost 102 pharmacies since 1996, many of these closures resulted in communities having no access to a local pharmacy.

In Minnesota there are 126 towns with one pharmacy, the total number of residents/patients served by these small town pharmacies is more than 226,000.

In towns that have only one pharmacy, the nearest opportunity to obtain pharmacy services is, on average, at least 22 miles away.

The average age of a pharmacist in rural Minnesota is 50 years.

Solutions:

Pharmacists in rural areas are facing challenges in reimbursement, competition, covering staffing and meeting increased medication needs of patients.

As more rural pharmacists reach retirement age, the number of pharmacies *closing without replacement is likely to increase.*

To maintain pharmacy services in rural areas, pharmacists must be:

- Maintain Medicaid reimbursement at current levels.
- Conform Minnesota pharmacy access standards to match the Medicare standard.
- Assure provider tax relief for losses incurred as a result of the Medicare Part D Benefit.
- Support loan forgiveness for rural pharmacists.

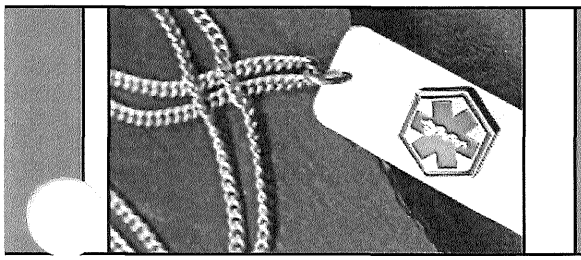
References

1. www.nrhrural.org/page.file/different.html "What's Different About Rural Health Care."

2. "Profile of Pharmacies in Rural Minnesota," Office of Rural Health and Primary Care, MN Dept. of Health.

3. Unpublished research from the College of Pharmacy, University of Minnesota, data collected 2003.

Minnesota Pharmacists Association, 1935 West County Road B-2, Suite 165, Roseville, Minnesota 55113-2722
800-451-8349-MN ✧ 651-697-1771-Metro ✧ 651-697-1776-Fax ✧ Contacts: liz@mpha.org or abbie@mpha.org



RURAL PHARMACY PRESERVATION ACT

ACCESS TO PHARMACISTS in rural Minnesota is nearing a crisis point. Pharmacies and pharmacists not only provide drug therapy and health care guidance regarding medications to patients coming into their pharmacy, they also serve local nursing homes, hospitals and other entities by providing medication reviews for patients, and ordering and delivering medications.

Rural pharmacy is fragile in today's environment due to increasing costs of doing business and continuous cuts to pharmacy reimbursement in both the public and private sectors. The result is many rural Minnesotans are loosing access to medications and the knowledge of a pharmacist. Incorporation of a rural pharmacy planning and transition grant program and rural loan forgiveness provides support to initiatives that preserve access to Pharmacy services for rural Minnesotans and assists rural communities in attracting pharmacists.

- A study of 126 rural communities with only one community pharmacy in Minnesota revealed that the 216,000 patients within these community's limits, would have to travel, on average, 22 miles to a neighboring community to receive medications. Not having access to a pharmacists or a pharmacy is also an issue for rural primary care clinics, health systems and rural communities.

- Minnesota loses 38 pharmacies per year: 10-12 of those community pharmacies are not replaced. From July 2004 to February 2005, Minnesota lost 22 pharmacies.

MAINTAINING LOCAL ACCESS TO MEDICATIONS AND THE KNOWLEDGE OF A PHARMACIST

- Through the grant program hospitals, clinics, pharmacies and communities can collaborate and explore options to maintain local access to medications and the skills of a pharmacist. This grant program for pharmacy is needed to keep up with and reverse pharmacy closures and loss of pharmacists in rural areas.

- The grant program will be funded by excess licensure fees paid by pharmacists, pharmacies and wholesalers and collected by the Board of Pharmacy. Since the Board's budget has remained at a fixed rate and the fees brought in from licensures have increased, excess revenues have been swept into the state's special revenue fund. The excess fees will be dedicated to the grant program, which will be administered by the Minnesota Department of Health. The initiative will help pharmacy sustain pharmacy.

- In addition, rural pharmacist loan forgiveness is another incentive to attract new graduates to the rural areas that are in need of a pharmacist. The current rural loan-forgiveness program, funded by the provider tax and wholesale drug distributor tax incurred by pharmacies, encourages students graduating from the health care professions to practice in rural areas. However, this program currently does not include pharmacists. With the growing pharmacist shortage in rural areas it is necessary to add pharmacists into the program.

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RURAL PHARMACY PRESERVATION EXAMPLES

Access to 24 hour pharmacy services was maintained in a rural hospital unable to find a pharmacist to provide pharmacy services. Luckily, a pharmacy 25 miles away was able to apply and receive a variance from the Minnesota Board of Pharmacy to have a pharmacist check the work of a technician in the hospital via web camera. The pharmacist also has access to medical records, labs, etc. from their remote location. Besides covering the dispensing needs of the hospital, the pharmacist also provides drug information and other clinical services to medical staff 24 hours a day. This service has allowed the hospital to have 24 access to a pharmacist, yet only pay for the services as the need them. This is critical in a small rural facility who's patient census may vary from 0-15 over the course of 2 days.

Submitted by:
Paul Iverson
Iverson Corner Drug
Bemidji, Minnesota

WILDERNESS COALITION OF THE NORTHLAND

The Wilderness Coalition of the Northland has received funding for a project in which pharmacists from St. Luke's Hospital (SLH) in Duluth will provide off-hour (night/weekend/holiday) consulting pharmacist services to the small, rural hospital members of the Coalition. As you probably know, hospitals in rural communities tend not to have pharmacists in the house 24/7. The SLH pharmacists will provide these services using web-based telecommunications technology which will enable them to access a patient's entire medical record in Aitkin (or Big Fork, Cook, Hibbing or the other participating communities). The goal of the project is to improve patient safety in these smaller hospitals by minimizing the number of first doses which are administered during off hours without a pharmacist first reviewing the order. The money from the grant will be used to purchase the equipment necessary to provide this service.

LONGVILLE LAKES CLINIC TELEPHARMACY

Longville, MN

The Longville Lakes Clinic received grant funding from the USDA Rural Utilities Service to create a telepharmacy system in order to make prescription medications available to patients of the Longville Lakes Clinic. Without this system, patients would have to travel a minimum of 60 miles round trip to the nearest pharmacy. Many of these patients are elderly patients who would have to travel a long distance on roads which are often difficult to travel because they are narrow and winding in addition to weather related factors.

In early 2002, the telepharmacy equipment was installed. The system connected the Longville Lakes Clinic with the Cuyuna Lakes Pharmacy in Crosby, Minnesota. Since that time, we have been able to provide patients with most prescription medications right from the telepharmacy system. Patients can consult with the pharmacist by video and voice connection provided through the system. Along with this, the Cuyuna Lakes Pharmacy will mail patients prescriptions to their homes free of charge if the patient needs a refill or if the medication is not available in the telepharmacy system. This system has offered a tremendous service to the Longville area and is operating very well.

Submitted by:

Theresa Sullivan
Organizational Support Administrator
Cuyuna Regional Medical Center
Crosby, Minnesota

March 22, 2005
25899 335th Ave.
Henderson, Minn. 56044

Health and Human Security Committee
Minnesota Senate
State Capitol
St. Paul, Minn.

Chair and Committee;

Please accept this written testimony in support of Senate File 1567, the Rural Pharmacy Preservation Act. Thank you for this opportunity.

My name is Doug Thomas. I live and work in Henderson, Minnesota and co-chair the Henderson Chamber of Commerce and chair its retail subcommittee. Eighteen months ago our local pharmacy closed after being purchased some three years earlier by a neighboring pharmacy from LeSueur. Of course the reason for closing was stated to be lack of revenues and heavier regulation of the pharmacy industry. The business had been in continuous operation for seventy years and was a thriving cornerstone in our small, but growing community sixty miles SW of Minneapolis.

As a result of the closing, twenty local community investors bought the business, completely restored the store, including the classic soda fountain, and re-opened the store without the pharmacy. Henderson's Main Street is a national historic preservation district so the corner drug store is key to preservation efforts. We then set about to recruit a pharmacist. With a terrific facility, strong community support (born out in a community survey), and promising population growth (33% in the past ten years), we thought our chances were quite good. Not so. The deck is stacked against young pharmacists who want to live and work in rural Minnesota, let alone own their own pharmacy.

I spent a good deal of time investigating the issues surrounding this situation and found that:

1) Pharmacy graduates are strapped with excessive student debt and few options for repayment other than finding the highest paying job, nearly always in a metro area.

2) Very few national chains have any interest in smaller communities, no matter how established the business.

3) Large companies offer incentives to new pharmacists that blatantly discriminate against rural pharmacies.

4) There is a serious lack of state support for rural pharmacy recruitment and retention.

The Rural Pharmacy Preservation Act, administered by the Minnesota Department of Health, can play an important part in restoring service to many areas of Minnesota. If we think hospitals and clinics are important to rural areas, we must also support their small town counterparts, rural pharmacies.

Although we in Henderson are involved in historic preservation, this is not a nostalgic issue. We are all about being creative and innovative about a new kind of partnering around the pharmacy and health care industry. Through extensive recruiting efforts, we recently signed on with Sibley Medical Center to bring medical clinic services to our community and are in hopes of building a medical arts facility to bring dental, chiropractic and possibly pharmacy services in an integrated fashion to our community. Without further support for new pharmacists, we stand little chance, even as close to the metro area as we are, of being successful in our recruiting efforts.

We ask for your support for this tremendous need in rural Minnesota and communities like Henderson that are working hard to maintain economic and health care integrity. Please vote for S.F. 1567. Thank you very much.

Sincerely,

Doug Thomas
Henderson Chamber of Commerce

Tyler Healthcare Center
Avera Health

240 Willow Street
P.O. Box 280
Tyler, MN 56178
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March 22, 2005

Dear Legislative Committee,

As a Critical Access Hospital located in Southwest Minnesota, Tyler Healthcare Center was very fortunate to receive funding through the Rural Hospital Planning and Transition Grant Program last year. We were identified as one of many rural communities that would likely be facing a critical pharmacy shortage because our local pharmacist was nearing retirement and had been unable to sell his retail pharmacy. Additionally, he had been the sole hospital pharmacist providing about 2 hours per day of hospital pharmacy coverage for many years.

The Rural Hospital Planning and Transition funding allowed us to 1) address critical needs with respect to the delivery of pharmacy services within our organization and in the community, and 2) establish a rural pharmacy residency practice partnership with the University of Minnesota. This program allowed us to establish a full time pharmacy residency position at our hospital. The pharmacy resident has worked to improve the delivery of pharmacy services in the inpatient and outpatient settings, provide support to existing medical staff with respect to medication use issues and participate in THC quality assurance activities.

With the success of the collaboration with the pharmacy residency program and recognition of the level of service improvement that has been generated by establishing a full-time equivalent pharmacist position in the organization, THC has decided to move from relying on a part-time contract arrangement with our local pharmacist and has hired the current pharmacy resident as a full-time staff pharmacist at the completion of her post-graduate educational experience (June '05). In addition, we plan to continue our relationship with the University of Minnesota Pharmaceutical Residency program and recruit another pharmacy practice resident for 2005-06, thus establishing two full-time pharmacist positions within the organization.

While the full scope of pharmacy services at THC continues to develop and mature, much has been learned from this experience already. We believe that this is a "Model that Works". We urge you to support any programs such as rural practice partnerships, loan forgiveness programs and other programs that could increase the number of pharmacists willing to work in rural communities.

From many perspectives, the results of the initiatives made possible from the Rural Hospital Planning and Transition Grant program have been highly positive and have allowed THC to establish a sustainable approach to pharmacy services after a period when the ability to do so was in question. Not only has the availability of pharmacist-staff been stabilized and increased, the ability for pharmacists to contribute to the overall medication use process at THC has expanded. This has allowed for a greater collaborative approach across multiple health disciplines, improving the medication use experience for patients receiving inpatient, outpatient and long-term care from THC.

Thank you for your continued support of rural healthcare services.

Sincerely,

Rhonda Wiering

Rhonda Wiering, RN, BC, LNHA
Patient Care Director

Senate Counsel, Research, and Fiscal Analysis

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Senate

State of Minnesota

S.F. No. 932 - Division of Costs for Certain ICF/MR Services

Author: Senator Becky Lourey

Prepared by: David Giel, Senate Research (296-7178)

Date: March 18, 2005

S.F. No. 932 eliminates the county share of costs for certain placements in intermediate care facilities for persons with mental retardation (ICFs/MR) and mandates development of a plan for future services to persons now served in ICFs/MR.

Section 1 (256B.19, subdivision 1) eliminates a provision that took effect on July 1, 2004, requiring counties to pay 20 percent of the nonfederal share (ten percent of the total cost) of placements exceeding 90 days in ICFs/MR with seven or more beds.

Section 2 requires the Department of Human Services, in consultation with interested parties, to develop recommendations regarding future services to persons now served in ICFs/MR and report by January 15, 2006.

DHS must consider consumer choice of services; consumers' service needs; the total cost of ICF/MR and alternative services to current ICF/MR residents; and whether it is state policy to maintain an ICF/MR system.

If state policy is to maintain ICFs/MR, the recommendations must define the purpose, types, and intended recipients of those services; define needed capacity; and assure adequate funding mechanisms for ICFs/MR and alternatives.

If alternative services are recommended to support some current ICF/MR residents, the recommendations must provide for transition planning and for adequate funding to meet the needs of ICF/MR residents.

DG:rdr

Senators Lourey; Koering; Johnson, D.E.; Kubly and Berglin introduced--

S.F. No. 932: Referred to the Committee on Health and Family Security.

A bill for an act

relating to human services; modifying the division of costs for ICFs/MR; requiring an ICF/MR plan; amending Minnesota Statutes 2004, section 256B.19, subdivision 1.

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

Section 1. Minnesota Statutes 2004, section 256B.19, subdivision 1, is amended to read:

Subdivision 1. [DIVISION OF COST.] The state and county share of medical assistance costs not paid by federal funds shall be as follows:

(1) beginning January 1, 1992, 50 percent state funds and 50 percent county funds for the cost of placement of severely emotionally disturbed children in regional treatment centers;

(2) beginning January 1, 2003, 80 percent state funds and 20 percent county funds for the costs of nursing facility placements of persons with disabilities under the age of 65 that have exceeded 90 days. This clause shall be subject to chapter 256G and shall not apply to placements in facilities not certified to participate in medical assistance; and

(3) ~~beginning July 1, 2004, 80 percent state funds and 20 percent county funds for the costs of placements that have exceeded 90 days in intermediate care facilities for persons with mental retardation or a related condition that have seven or more beds. This provision includes pass-through payments~~

~~made under section 256B.5015; and~~

~~(4)~~ beginning July 1, 2004, when state funds are used to pay for a nursing facility placement due to the facility's status as an institution for mental diseases (IMD), the county shall pay 20 percent of the nonfederal share of costs that have exceeded 90 days. This clause is subject to chapter 256G.

For counties that participate in a Medicaid demonstration project under sections 256B.69 and 256B.71, the division of the nonfederal share of medical assistance expenses for payments made to prepaid health plans or for payments made to health maintenance organizations in the form of prepaid capitation payments, this division of medical assistance expenses shall be 95 percent by the state and five percent by the county of financial responsibility.

In counties where prepaid health plans are under contract to the commissioner to provide services to medical assistance recipients, the cost of court ordered treatment ordered without consulting the prepaid health plan that does not include diagnostic evaluation, recommendation, and referral for treatment by the prepaid health plan is the responsibility of the county of financial responsibility.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

Sec. 2. [ICF/MR PLAN.]

The commissioner of human services shall consult with ICF/MR providers, advocates, counties, and consumer families to develop recommendations and legislation concerning the future services provided to people now served in ICFs/MR. The recommendations shall be reported to the house and senate committees with jurisdiction over health and human services policy and finance issues by January 15, 2006. In preparing the recommendations, the commissioner shall consider:

(1) consumer choice of services;

(2) consumers' service needs, including, but not limited to, active treatment;

(3) the total cost of providing services in ICFs/MR and

alternative delivery systems for individuals currently residing in ICFs/MR;

(4) whether it is the policy of the state to maintain an ICF/MR system and, if so, the recommendations shall:

(i) define the purpose, types of services, and intended recipients of ICF/MR services;

(ii) define the capacity needed to maintain ICF/MR services for designated populations; and

(iii) assure that mechanisms are provided to adequately fund the transition to the defined services, maintain the designated capacity, and are adjustable to meet increased service demands; and

(5) if alternative services are recommended to support some of the people now receiving services in an ICF/MR, the recommendations shall provide for transition planning and ensure adequate financial resources are available to meet the needs of ICF/MR recipients.

[EFFECTIVE DATE.] This section is effective the day following final enactment.

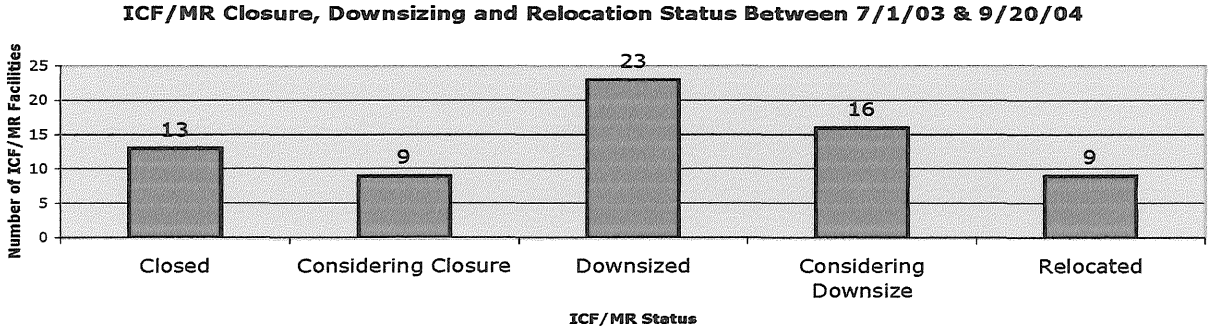
Senator Lourey moves to amend S.F. No. 932 as follows:

Page 3, lines 13 and 14, delete "some of"

Page 3, line 16, after "adequate" insert "state and federal"

2005 ARRM Policy Agenda ICF/MR Cost Shift Factoid

70 ICFs/MR (31%) went through or considered a status change since 7/1/03, see chart below.
In particular, 36 ICFs/MR closed or downsized between 7/1/03 and 9/20/04.



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56 ICFs/MR, out of the 70 above, are owned by Member Organizations.
ARRM collected data on all 56. The following are the results of our research.

Members reported the status change for 32 ICFs/MR (57%) was due to the county cost shift.

How Change was Due to Cost Shift	Frequency of Response
• County initiated it (18 counties)	22
• Organization received inadequate referrals	2
• Organization initiated it	2
• Both county and organization are waiting for funds or waiting for a repeal of the county cost shift	6

24 of the Closed or Downsized ICFs/MR are owned by Member Organizations.
80% of these 24 programs reported the activity was due to the county cost shift.

Looming Pressures on the System

- The cost shift exacerbates the threat of open beds to the viability of an ICF/MR. It creates an accidental fiscal incentive for counties to allow vacancies to go unutilized, saving the county money. Providers have reported experiencing reluctance by some counties to fill empty beds.
- Per-diems tend to increase for clients moving out of ICFs/MR into the Waiver. ARRM's ICF/MR Closure Study (2004) showed costs to be higher for persons moving from ICF/MR to Waiver services.
- Counties that are spending close to their waiver budget are struggling to find adequate resources to develop waiver programs for clients forced to move from ICFs/MR.
- Currently, 48% of the ICFs/MR (108 out of 227) have more than 6 beds. Of these, at least 60% went through or are considering a status change between 7/1/03 and 9/20/04.
- The number of ICF/MR closures, downsizings, relocations and pending changes totals 969 beds or 43% of all ICF/MR beds. This large number indicates the cost shift has developed a precarious bubble in the system.

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S.F. No. 1482 - Isolation and Quarantine Provision Modifications

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 21, 2005

S.F. No. 1482 modifies the isolation and quarantine provisions in Minnesota Statutes, chapter 144.

Section 1 (144.419, subdivision1) is a conforming technical change.

Section 2 (144.4195, subdivision 1) requires any peace officer to enforce an ex parte order for isolation or quarantine obtained by the Commissioner of Health and permits the officer to use all necessary and lawful means to transport, quarantine, or isolate the subject of the order. "Necessary and lawful" is defined to include reasonable force but not deadly force. The commissioner or the local board of health must, upon request, advise the officer on protective measures to protect the officer from possible transmission of the communicable disease. The officer may act upon a telephone, facsimile, or other electronic notification of the order from the court, Commissioner of Health, local board of health, or Commissioner of Public Safety.

Section 3 (144.4195, subdivision 2), paragraph (a), states that when the commissioner issues a directive to isolate or quarantine a person or group of persons without a court order, the directive must specify the known period of incubation or communicability of the communicable disease or the estimated period of incubation under the commissioner's best medical judgment when the disease is unknown. The directive shall remain in place for the period specified on the directive unless amended by the commissioner or superceded by a court order. Upon executing a directive and initiating notice to the parties subject to it, the commissioner must apply for a written ex parte order authorizing the isolation or quarantine. (Currently, this must be done within 24 hours of the imposition of the directive; however, this section removes this time limit.) The court must rule on the ex parte order filed by the commissioner within 24 hours or as soon as practicable. (Currently, the court must rule within 24 hours.) This section also strikes the language that prohibits holding

a person in isolation or quarantine after the temporary hold expires unless an ex parte order has been issued.

Paragraph (b) requires a peace officer to enforce the commissioner's directive and may use all necessary and lawful means to apprehend, hold, transport, quarantine, or isolate a person subject to the directive. Necessary and lawful includes reasonable but not deadly force. The commissioner or local board of health must, upon request, advise the officer on protective measures to protect the officer from possible transmission of the communicable disease. The officer may act upon a telephone, facsimile, or other electronic notification of the order from the court, Commissioner of Health, local board of health, or Commissioner of Public Safety.

Paragraph (c) states that if the subject of the directive is already institutionalized in an appropriate health care facility, the commissioner may direct the facility to continue to hold the person. The facility must take all reasonable measures to prevent the person from exposing others to the communicable disease.

Section 4 (144.4195, subdivision 5), paragraph (b), states that any person subject to isolation or quarantine who is not represented by counsel at the court hearing may request the court to appoint counsel at the expense of the Department of Health or local board of health if the commissioner has delegated its authority to the local board. Appointments and counsel compensation shall be made according to procedures developed by the Supreme Court, and the commissioner, upon counsel's request, must advise on protective measures to protect counsel from possible transmission of the communicable disease. The appointed counsel is not required to pursue an appeal if in the opinion of counsel there is insufficient basis for the appeal.

Paragraph (c) authorizes the court to conduct the hearing by telephonic, interactive video, or other electronic means to maintain isolation or quarantine precautions and reduce the spread of a communicable disease.

Section 5 (144.4196) establishes employee protections.

Subdivision 1 defines "qualifying employee" and "employer."

Subdivision 2, paragraph (a), states that an employer shall not discharge, discipline, threaten, or penalize, or otherwise discriminate against a qualifying employee because the employee has been in isolation or quarantine.

Paragraph (b) states that a qualifying employee claiming a violation of **paragraph (a)** may bring a civil action for recovery of lost wages or benefits, or other relief within 180 days of the claimed violation or 180 days from the end of the isolation or quarantine, whichever is later. If the employee prevails, the court shall award the employee reasonable attorney fees.

Paragraph (c) states that this subdivision does not alter sick leave or sick pay in terms of the employment relationship.

Subdivision 3 states that **subdivision 2** does not apply to work absences due to isolation or quarantine for periods longer than 21 consecutive days, but that absences for periods longer than 21 days resulting in loss of employment will be treated for purposes of unemployment compensation in the same manner as loss of employment due to a serious illness.

Section 6 (144.4197) states that when a local emergency is declared under section 12.29 or the Governor declares an emergency under section 12.31 (national security or peacetime emergency), the commissioner may authorize any person licensed or credentialed under chapters 144E, 147 to 148, 150A, 151, 153, or 156 to administer vaccinations or dispense prescription drugs if it is determined that such an action is necessary to protect the health and safety of the public. The authorization must be in writing and shall contain the categories of persons included in the authorization, any additional training required, any supervision required, and the duration of the authorization. The commissioner may extend the scope and duration of the authorization. Any person authorized under this section shall not be subject to criminal liability, administrative penalty, professional discipline, or other administrative sanction for good-faith performance of these duties.

Section 7 sunsets sections 1 to 17 of the Emergency Health Powers Act passed in 2002.

Section 8 provides an effective date of the day following final enactment.

KC:ph

Senators Lourey, Higgins, Kiscaden, McGinn and LeClair introduced--
S.F. No. 1482: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying provisions for isolation and quarantine of persons exposed to or infected with a communicable disease; amending Minnesota Statutes 2004, sections 144.419, subdivision 1; 144.4195, subdivisions 1, 2, 5; Laws 2002, chapter 402, section 21, as amended; proposing coding for new law in Minnesota Statutes, chapter 144.

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

Section 1. Minnesota Statutes 2004, section 144.419, subdivision 1, is amended to read:

Subdivision 1. [DEFINITIONS.] For purposes of ~~this section and section 144.4195~~ sections 144.419 to 144.4196, the following definitions apply:

(1) "bioterrorism" means the intentional use of any microorganism, virus, infectious substance, or biological product that may be engineered as a result of biotechnology, or any naturally occurring or bioengineered component of any such microorganism, virus, infectious substance, or biological product, to cause death, disease, or other biological malfunction in a human, an animal, a plant, or another living organism in order to influence the conduct of government or to intimidate or coerce a civilian population;

(2) "communicable disease" means a disease caused by a living organism or virus and believed to be caused by bioterrorism or a new or novel or previously controlled or eradicated infectious agent or biological toxin that can be

transmitted person to person and for which isolation or quarantine is an effective control strategy, excluding a disease that is directly transmitted as defined under section 144.4172, subdivision 5;

(3) "isolation" means separation, during the period of communicability, of a person infected with a communicable disease, in a place and under conditions so as to prevent direct or indirect transmission of an infectious agent to others; and

(4) "quarantine" means restriction, during a period of communicability, of activities or travel of an otherwise healthy person who likely has been exposed to a communicable disease to prevent disease transmission during the period of communicability in the event the person is infected.

Sec. 2. Minnesota Statutes 2004, section 144.4195, subdivision 1, is amended to read:

Subdivision 1. [EX PARTE ORDER FOR ISOLATION OR QUARANTINE.] (a) Before isolating or quarantining a person or group of persons, the commissioner of health shall obtain a written, ex parte order authorizing the isolation or quarantine from the District Court of Ramsey County, the county where the person or group of persons is located, or a county adjoining the county where the person or group of persons is located. The evidence or testimony in support of an application may be made or taken by telephone, facsimile transmission, video equipment, or other electronic communication. The court shall grant the order upon a finding that probable cause exists to believe isolation or quarantine is warranted to protect the public health.

(b) The order must state the specific facts justifying isolation or quarantine, must state that the person being isolated or quarantined has a right to a court hearing under this section and a right to be represented by counsel during any proceeding under this section, and must be provided immediately to each person isolated or quarantined. The commissioner of health shall provide a copy of the authorizing order to the commissioner of public safety and other peace officers known to

the commissioner to have jurisdiction over the site of the isolation or quarantine. If feasible, the commissioner of health shall give each person being isolated or quarantined an estimate of the expected period of the person's isolation or quarantine.

(c) If it is impracticable to provide individual orders to a group of persons isolated or quarantined, one order shall suffice to isolate or quarantine a group of persons believed to have been commonly infected with or exposed to a communicable disease. A copy of the order and notice shall be posted in a conspicuous place:

(1) in the isolation or quarantine premises, but only if the persons to be isolated or quarantined are already at the isolation or quarantine premises and have adequate access to the order posted there; or

(2) in another location where the group of persons to be isolated or quarantined is located, such that the persons have adequate access to the order posted there.

If the court determines that posting the order according to clause (1) or (2) is impractical due to the number of persons to be isolated or quarantined or the geographical area affected, the court must use the best means available to ensure that the affected persons are fully informed of the order and notice.

(d) Any peace officer, as defined in section 144.4803, subdivision 16, shall enforce an order under this section and may use all necessary and lawful means to apprehend, hold, transport, quarantine, or isolate a person subject to the order. "Necessary and lawful means" include reasonable force but not deadly force as defined in section 609.066, subdivision 1. The commissioner or an agent of a local board of health authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the order from the court, commissioner of health, agent of a local board of health, or

commissioner of public safety.

(e) No person may be isolated or quarantined pursuant to an order issued under this subdivision for longer than 21 days without a court hearing under subdivision 3 to determine whether isolation or quarantine should continue. A person who is isolated or quarantined may request a court hearing under subdivision 3 at any time before the expiration of the order.

Sec. 3. Minnesota Statutes 2004, section 144.4195, subdivision 2, is amended to read:

Subd. 2. [TEMPORARY HOLD UPON COMMISSIONER'S DIRECTIVE.] (a) Notwithstanding subdivision 1, the commissioner of health may by directive isolate or quarantine a person or group of persons without first obtaining a written, ex parte order from the court if a delay in isolating or quarantining the person or group of persons would significantly jeopardize the commissioner of health's ability to prevent or limit the transmission of a communicable or potentially communicable disease to others. The directive shall specify the known period of incubation or communicability or the estimated period under the commissioner's best medical judgment when the disease is unknown. The directive remains in effect for the period specified unless amended by the commissioner or superseded by a court order. The commissioner must provide the person or group of persons subject to the temporary hold with notice that the person has a right to request a court hearing under this section and a right to be represented by counsel during a proceeding under this section. If it is impracticable to provide individual notice to each person subject to the temporary hold, notice of these rights may be posted in the same manner as the posting of orders under subdivision 1, paragraph (c). ~~Following the imposition of isolation or quarantine under this subdivision~~ As soon as the commissioner has executed the directive and initiated notice of the parties subject to it, the commissioner ~~of health~~ shall ~~within 24 hours~~ initiate the process to apply for a written, ex parte order pursuant to subdivision 1 authorizing the isolation or quarantine. The court must rule within 24 hours of receipt

of the application or as soon as practicable thereafter. ~~If the person is under a temporary hold, the person may not be held in isolation or quarantine after the temporary hold expires unless the court issues an ex parte order under subdivision 1.~~

(b) Any peace officer, as defined in section 144.4803, subdivision 16, shall enforce a commissioner's directive under paragraph (a), and may use all necessary and lawful means to apprehend, hold, transport, quarantine, or isolate a person subject to the order. "Necessary and lawful means" include reasonable force but not deadly force as defined in section 609.066, subdivision 1. The commissioner or an agent of a local board of health authorized under section 145A.04 shall advise the peace officer on request of protective measures recommended to protect the officer from possible transmission of the communicable disease. The peace officer may act upon telephone, facsimile, or other electronic notification of the order from the court, commissioner of health, agent of a local board of health, or commissioner of public safety.

(c) If a person subject to a commissioner's directive under paragraph (a) is already institutionalized in an appropriate health care facility, the commissioner of health may direct the facility to continue to hold the person. The facility shall take all reasonable measures to prevent the person from exposing others to the communicable disease.

Sec. 4. Minnesota Statutes 2004, section 144.4195, subdivision 5, is amended to read:

Subd. 5. [JUDICIAL PROCEDURES AND DECISIONS.] (a) Court orders issued pursuant to subdivision 3 or 4 shall be based upon clear and convincing evidence and a written record of the disposition of the case shall be made and retained.

(b) Any person subject to isolation or quarantine has the right to be represented by counsel ~~or other lawful representative~~. Persons not otherwise represented may request the court to appoint counsel at the expense of the Department of Health or of a local public health board that has entered into a written delegation agreement with the commissioner under

subdivision 7. The court shall appoint counsel when so requested and may have one counsel represent a group of persons similarly situated. The appointments shall be only for representation under subdivisions 3 and 4 and for appeals of orders under subdivisions 3 and 4. On counsel's request, the commissioner or an agent of a local board of health authorized under section 145A.04 shall advise counsel of protective measures recommended to protect counsel from possible transmission of the communicable disease. Appointments shall be made and counsel compensated according to procedures developed by the Supreme Court. Counsel appointed for a respondent is not required to pursue an appeal if, in the opinion of counsel, there is insufficient basis for proceeding.

(c) The court may choose to conduct a hearing under subdivision 3 or 4 by telephonic, interactive video, or other electronic means to maintain isolation or quarantine precautions and reduce the risk of spread of a communicable disease. Otherwise, the manner in which the request for a hearing is filed and acted upon shall be in accordance with the existing laws and rules of the courts of this state or, if the isolation or quarantine occurs during a national security or peacetime emergency, any rules that are developed by the courts for use during a national security or peacetime emergency.

Sec. 5. [144.4196] [EMPLOYEE PROTECTION.]

Subdivision 1. [DEFINITIONS.] For purposes of this section:

(1) "qualifying employee" means a person who performs services for hire in Minnesota and who has been subject to isolation or quarantine for a communicable disease as defined in section 144.419, subdivision 1, clause (2). The term applies to persons who comply with isolation or quarantine restrictions because of:

(i) a commissioner's directive;

(ii) an order of a federal quarantine officer;

(iii) a state or federal court order; or

(iv) a written recommendation of the commissioner or designee that the person enter isolation or quarantine; and

(2) "employer" means any person having one or more employees in Minnesota and includes the state and any political subdivision of the state.

Subd. 2. [PROTECTIONS.] (a) An employer shall not discharge, discipline, threaten, or penalize a qualifying employee, or otherwise discriminate in the work terms, conditions, location, or privileges of the employee, because the employee has been in isolation or quarantine.

(b) A qualifying employee claiming a violation of paragraph (a) may bring a civil action for recovery of lost wages or benefits, for reinstatement, or for other relief within 180 days of the claimed violation or 180 days of the end of the isolation or quarantine, whichever is later. A qualifying employee who prevails shall be allowed reasonable attorney fees fixed by the court.

(c) Nothing in this subdivision is intended to alter sick leave or sick pay terms of the employment relationship.

Subd. 3. [LIMITATIONS.] The protections of subdivision 2 do not apply to work absences due to isolation or quarantine for periods longer than 21 consecutive work days. However, absences due to isolation or quarantine for periods longer than 21 consecutive work days resulting in loss of employment shall be treated for purposes of unemployment compensation in the same manner as loss of employment due to a serious illness.

Sec. 6. [144.4197] [EMERGENCY VACCINE ADMINISTRATION AND LEGEND DRUG DISPENSING.]

When a mayor, county board chair, or legal successor to such official has declared a local emergency under section 12.29 or the governor has declared an emergency under section 12.31, subdivision 1 or 2, the commissioner of health may authorize any person, including, but not limited to, any person licensed or otherwise credentialed under chapters 144E, 147 to 148, 150A, 151, 153, or 156, to administer vaccinations or dispense legend drugs if the commissioner determines that such action is necessary to protect the health and safety of the public. The authorization shall be in writing and shall contain the

categories of persons included in the authorization, any additional training required before performance of the vaccination or drug dispensing by such persons, any supervision required for performance of the vaccination or drug dispensing, and the duration of the authorization. The commissioner may, in writing, extend the scope and duration of the authorization as the emergency warrants. Any person authorized by the commissioner under this section shall not be subject to criminal liability, administrative penalty, professional discipline, or other administrative sanction for good faith performance of the vaccination or drug dispensing duties assigned according to this section.

Sec. 7. Laws 2002, chapter 402, section 21, as amended by Laws 2004, chapter 279, article 11, section 7, is amended to read:

Sec. 21. [SUNSET.]

Section 1 to ~~19~~ 17 expire August 1, 2005.

Sec. 8. [EFFECTIVE DATE.]

Section 7 is effective the day following final enactment.

Senator ..... moves to amend S.F. No. 1482 as follows:

Pages 6 and 7, delete section 5

Page 8, delete lines 16 and 17 and insert:

"Sec. 21. [SUNSET.]

Sections 1 ~~to 19~~, 2, 5, 8, 10, and 11 expire August 1, 2005."

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

Senator ..... moves to amend S.F. No. 1482 as follows:

Pages 6 and 7, delete section 5

Page 8, line 17, delete "17" and insert "16"

Renumber the sections in sequence and correct the internal references

Amend the title accordingly

withdrawn

Policy Position

Minnesota Department of Health March 22, 2005

Isolation and Quarantine Procedures

SF 1482 HF 1507

Isolation and Quarantine Procedures

In 2002, the Minnesota Legislature approved protections for people infected with or exposed to a communicable disease who may require isolation or quarantine. These included provisions for expedited court hearings and health and safety protection. The 2004 legislature voted to retain those provisions, **which are now scheduled to expire in August 2005.**

Recent events at the global level demonstrate the need to continue these provisions. These events include the 2003 SARS outbreak, current reports of avian influenza (bird flu) in Asia, and the continuing risk of bioterrorism. SARS caused 8,098 cases of illness and 774 deaths worldwide in 2003. **In Minnesota, 11 people were evaluated as potential SARS cases.** The experience of Toronto – with hundreds of cases, 44 deaths, and 27,000 persons in quarantine – illustrates how quickly government must be ready to act to protect public health. The 27 administrative orders for quarantine in Toronto show that health protection requires the use of limited – but significant – legal powers.

Exercises conducted in Minnesota at the state and local level – involving public health, emergency responders, and the court system – have highlighted the need for an effective legal framework governing isolation and quarantine procedures. Appropriate statutory provisions will ensure the consistent application of authority, and lay out the procedures to be followed in advance of an actual event.

Provisions to be Retained

1. **Right to refuse** testing and treatment.
2. **Expedited court hearings** and administrative action.
3. **Health and safety requirements** for persons in isolation or quarantine.
4. A **court administered process for intervening** if an individual's health and safety needs are not met.

New Provisions

1. Clarification of peace officer authority for **enforcing isolation or quarantine** under a commissioner's temporary hold or a court order.
2. Modification of commissioner's temporary hold to **start court process immediately** and make hold as short as possible.
3. Establishment of a process for **appointment and payment of defense counsel.**
4. Dissemination of **information about personal protection** to peace officers and defense counsel.
5. Authorization to hold court hearings regarding isolation or quarantine through **electronic means.**
6. Provision for the commissioner of health to authorize persons who can assist in providing **vaccinations or medications in an emergency.**

Who is affected?

All Minnesotans are potentially affected by a communicable disease outbreak. Experience in Toronto and other areas has shown clarity of public health roles and responsibilities to be critical in protecting lives and property, and sustaining the economy.

Sick or exposed individuals *will have the right* to expedited court hearings, rapid access to defense counsel, job protection, and isolation or quarantine in the least restrictive setting possible.

MINNESOTA MDH DEPARTMENT OF HEALTH

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(OVER)

Isolation and Quarantine Procedures Page 2

Local and state government personnel, and health care providers, will have a clear understanding of their roles and responsibilities during a communicable disease outbreak.

What are the consequences if this legislation does not pass?

1. The commissioner of health will have to rely on general laws written over 100 years ago in managing a communicable disease outbreak.

2. Modernized and expedited procedures to assure due process will not be available for individuals who are recommended for – or ordered to be placed in – isolation or quarantine.

3. Individuals may have difficulty complying with isolation or quarantine recommendations because they have no guarantees that their health and safety will be protected, and they have not been afforded employment protection.

4. The public's risk of exposure to individuals who are sick or may have been infected with a communicable disease will be much greater, and the potential for additional disease transmission will be increased.

Individuals and groups providing input to date:

Task Force on Terrorism and Health
Homeland Security Advisory Committee
State Com. Health Services Adv. Committee
Minnesota Local Public Health Association
Minnesota Hospital Association
Minnesota Medical Association
Minnesota Board of Medical Practice
Minnesota Dental Association
County Attorney's Association
Minnesota Council of Health Plans
Minnesota Public Health Association
Association of Minnesota Counties
Department of Public Safety
Ramsey County Court Administrator
Minnesota Business Partnership
Minnesota Chamber of Commerce
Minnesota Board of Nursing
Minnesota Ambulance Association
Minnesota Nurses Association

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Senate
State of Minnesota

S.F. No. 1483 - Modifying Provisions in the Emergency Health Powers Act

Author: Senator Becky Lourey

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KTC

Date: March 21, 2005

S.F. No. 1483 modifies the Minnesota Emergency Health Powers Act of 2002.

Section 1 (12.03, subdivision 1e) adds a definition in chapter 12 (the Minnesota Emergency Management Chapter) for "declared emergency."

Section 2 (12.03, subdivision 4d) states that the definition of "facility" includes a licensed health care facility but only when other alternatives are not feasible.

Section 3 (12.22, subdivision 2a) clarifies that individuals who volunteer to assist a local political subdivision during an emergency or disaster, who register with the subdivision, and who are under the direction or control of the subdivision are considered an employee of the subdivision for purposes of workers' compensation and tort claim defense and indemnification. This section also extends this to individuals who volunteer to assist the state during an emergency or disaster.

Section 4 (12.22, subdivision 4) states that nothing in chapter 12 is to be construed to remove any immunity from, defense to, or limitation on liability provided in law.

Section 5 (12.31, subdivision 1) strikes the reference to a public health emergency from the list of emergencies that may trigger the Governor to declare a national security emergency.

Section 6 (12.32) extends the powers given to the Governor's orders and rules promulgated during an emergency to include those orders and rules promulgated during the declaration of a peacetime emergency. (Currently, this only extends to a national security emergency, a peacetime emergency declared due to a public health emergency, or an energy supply emergency.)

Section 7 (12.34) extends the provisions relating to the taking of property during an emergency to apply when a peacetime emergency is declared. (Currently, these provisions only apply during a national security emergency or during a peacetime emergency declared due to a public health emergency.)

Section 8 (12.381) extends the provisions for the safe disposition of dead human bodies to deaths related to a declared emergency. (Currently, these provisions only apply to a national security emergency declared due to a public health emergency or a peacetime emergency declared due to a public health emergency).

Section 9 ((12.39) strikes the reference to a "public health emergency." This section also strikes "where feasible" thereby requiring a health care provider to notify the individual of the right to refuse the examination, testing, treatment, or vaccination before performing an examination, test, treatment, or vaccination during the declaration of an emergency.

Section 10 (12.42) permits an individual who is licensed in the District of Columbia or a province of Canada to render aid during a declared emergency when such aid is requested by the Governor.

Section 11 (12.61) authorizes the Governor to issue an emergency executive order when the hospital and medical transport capacities are exceeded.

Subdivision 1 defines "emergency plan," "regional hospital system," and "responder."

Subdivision 2 states that during a declared national security or peacetime emergency the Governor may issue an emergency executive order when the number of seriously ill or injured persons exceeds the emergency hospital or medical transport capacity of one or more regional hospital systems requiring care to be given in temporary care facilities. During this period, a responder who is acting consistent with the emergency plans is not liable for any civil damages or administrative sanctions as a result of good-faith acts or omissions in rendering care, advice, or assistance, but does not apply in the case of malfeasance in office or willful or wanton actions.

Section 12 (13.3806, subdivision 1a) extends the death investigation data classification to data gathered to identify bodies believed to have died due to a declared emergency. (Currently, this only applies during a public health emergency.)

Section 13 sunsets **sections 2, 5, 8, 10, and 11** from the Emergency Health Powers Act passed in 2002. This has the following effect:

Section 2 – strikes the definition of "bioterrorism" from chapter 12

Section 5 – strikes the definition of "public health emergency" from chapter 12.

Section 8 – strikes "public health emergency" in the list of situations that justifies the declaration of a peacetime emergency by the Governor (section 12.31, subdivision 2).

Section 10 – repeals section 12.311 (authorizes the Governor to declare a national security emergency or a peacetime emergency due to a public health emergency).

Section 11 – repeals section 12.312 ((describes the termination of a public health emergency).

KC:ph

Senators Lourey, LeClair, Higgins, Kiscaden and McGinn introduced--

S.F. No. 1483: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health; modifying the Minnesota Emergency Health Powers Act; modifying authority of out-of-state license holders; amending Minnesota Statutes 2004, sections 12.03, subdivision 4d, by adding a subdivision; 12.22, subdivision 2a, by adding a subdivision; 12.31, subdivision 1; 12.32; 12.34, subdivision 1; 12.381; 12.39; 12.42; 13.3806, subdivision 1a; Laws 2002, chapter 402, section 21, as amended; proposing coding for new law in Minnesota Statutes, chapter 12.

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

Section 1. Minnesota Statutes 2004, section 12.03, is amended by adding a subdivision to read:

Subd. 1e. [DECLARED EMERGENCY.] "Declared emergency" means a national security or peacetime emergency declared by the governor under section 12.31.

Sec. 2. Minnesota Statutes 2004, section 12.03, subdivision 4d, is amended to read:

Subd. 4d. [FACILITY.] "Facility" means any real property, building, structure, or other improvement to real property or any motor vehicle, rolling stock, aircraft, watercraft, or other means of transportation. Facility does not include a private residence but may include a licensed health care facility only when other alternatives are not feasible.

Sec. 3. Minnesota Statutes 2004, section 12.22, subdivision 2a, is amended to read:

Subd. 2a. [VOLUNTEER ~~ASSISTANCE~~ PROTECTIONS.] (a)

Individuals who volunteer to assist a local political subdivision during an emergency or disaster, who register with that subdivision, and who are under the direction and control of that subdivision~~,~~ are considered an employee of that subdivision for purposes of workers' compensation and tort claim defense and indemnification.

(b) Individuals who volunteer to assist the state during an emergency or disaster, who register with a state agency, and who are under the direction and control of the state agency are considered an employee of the state for purposes of workers' compensation and tort claim defense and indemnification.

Sec. 4. Minnesota Statutes 2004, section 12.22, is amended by adding a subdivision to read:

Subd. 4. [OTHER LAW PRESERVED.] Nothing in this chapter shall be construed to remove any immunity from, defense to, or limitation on liability provided by the Minnesota Tort Claims Act, the Municipal Tort Claims Act, or other law.

Sec. 5. Minnesota Statutes 2004, section 12.31, subdivision 1, is amended to read:

Subdivision 1. [DECLARATION OF NATIONAL SECURITY EMERGENCY.] When information from the President of the United States, the Federal Emergency Management Agency, the Department of Defense, or the National Warning System indicates the imminence of a national security emergency within the United States, which means the several states, the District of Columbia, and the Commonwealth of Puerto Rico, or the occurrence within the state of Minnesota of a major disaster ~~or public health emergency~~ from enemy sabotage or other hostile action, the governor may, by proclamation, declare that a national security emergency exists in all or any part of the state. If the legislature is then in regular session or, if it is not, if the governor concurrently with the proclamation declaring the emergency issues a call convening immediately both houses of the legislature, the governor may exercise for a period not to exceed 30 days the powers and duties conferred and imposed by sections 12.31 to 12.37 and 12.381. The lapse of these

emergency powers does not, as regards any act occurring or committed within the 30-day period, deprive any person, political subdivision, municipal corporation, or body politic of any right to compensation or reimbursement that it may have under this chapter.

Sec. 6. Minnesota Statutes 2004, section 12.32, is amended to read:

12.32 [GOVERNOR'S ORDERS AND RULES, EFFECT.]

Orders and rules promulgated by the governor under authority of section 12.21, subdivision 3, clause (1), when approved by the Executive Council and filed in the Office of the Secretary of State, have, during a national security emergency, peacetime emergency ~~declared due to a public health emergency~~, or energy supply emergency, the full force and effect of law. Rules and ordinances of any agency or political subdivision of the state inconsistent with the provisions of this chapter or with any order or rule having the force and effect of law issued under the authority of this chapter, is suspended during the period of time and to the extent that the emergency exists.

Sec. 7. Minnesota Statutes 2004, section 12.34, subdivision 1, is amended to read:

Subdivision 1. [EMERGENCY POWERS.] When necessary to save life, property, or the environment during a national security emergency or during a peacetime emergency ~~declared due to a public health emergency~~, the governor, the state director, or a member of a class of members of a state or local emergency management organization designated by the governor, may:

(1) require any person, except members of the federal or state military forces and officers of the state or a political subdivision, to perform services for emergency management purposes as directed by any of the persons described above; and

(2) commandeer, for emergency management purposes as directed by any of the persons described above, any motor vehicles, tools, appliances, medical supplies, or other personal property and any facilities.

Sec. 8. Minnesota Statutes 2004, section 12.381, is

amended to read:

12.381 [SAFE DISPOSITION OF DEAD HUMAN BODIES.]

Subdivision 1. [POWERS FOR SAFE DISPOSITION.] Notwithstanding chapter 149A and Minnesota Rules, chapter 4610, in connection with deaths related to a ~~public-health~~ declared emergency ~~and-during-a-national-security-emergency-declared-due-to-a-public-health-emergency-or-peacetime-emergency-declared-due-to-a-public-health-emergency~~, the governor may:

(1) direct measures to provide for the safe disposition of dead human bodies as may be reasonable and necessary for emergency response. Measures may include, but are not limited to, transportation, preparation, temporary mass burial and other interment, disinterment, and cremation of dead human bodies. Insofar as the emergency circumstances allow, the governor shall respect the religious rites, cultural customs, family wishes, and predeath directives of a decedent concerning final disposition. The governor may limit visitations or funeral ceremonies based on public health risks;

(2) consult with coroners and medical examiners, take possession or control of any dead human body, and order an autopsy of the body; and

(3) request any business or facility authorized to embalm, bury, cremate, inter, disinter, transport, or otherwise provide for disposition of a dead human body under the laws of this state to accept any dead human body or provide the use of its business or facility if the actions are reasonable and necessary for emergency management purposes and are within the safety precaution capabilities of the business or facility.

Subd. 2. [IDENTIFICATION OF BODIES; DATA CLASSIFICATION.] (a) A person in charge of the body of a person believed to have died due to a ~~public-health~~ declared emergency shall maintain a written record of the body and all available information to identify the decedent, the circumstances of death, and disposition of the body. If a body cannot be identified, a qualified person shall, prior to disposition and to the extent possible, take fingerprints and one or more photographs of the

remains and collect a DNA specimen from the body.

(b) All information gathered under this subdivision, other than data required for a death certificate under Minnesota Rules, part 4601.2550, shall be death investigation data and shall be classified as nonpublic data according to section 13.02, subdivision 9, or as private data on decedents according to section 13.10, subdivision 1. Death investigation data are not medical examiner data as defined in section 13.83. Data gathered under this subdivision shall be promptly forwarded to the commissioner of health. The commissioner may only disclose death investigation data to the extent necessary to assist relatives in identifying decedents or for public health or public safety investigations.

Sec. 9. Minnesota Statutes 2004, section 12.39, is amended to read:

12.39 [INDIVIDUAL TESTING OR TREATMENT; NOTICE, REFUSAL, CONSEQUENCE.]

Subdivision 1. [REFUSAL OF TREATMENT.] Notwithstanding laws, rules, or orders made or promulgated in response to a national security emergency~~,~~ or peacetime emergency, ~~or public health emergency,~~ individuals have a fundamental right to refuse medical treatment, testing, physical or mental examination, vaccination, participation in experimental procedures and protocols, collection of specimens, and preventive treatment programs. An individual who has been directed by the commissioner of health to submit to medical procedures and protocols because the individual is infected with or reasonably believed by the commissioner of health to be infected with or exposed to a toxic agent that can be transferred to another individual or a communicable disease, and the agent or communicable disease is the basis for which the national security emergency~~,~~ or peacetime emergency~~,~~ ~~or public health emergency~~ was declared, and who refuses to submit to them may be ordered by the commissioner to be placed in isolation or quarantine according to parameters set forth in sections 144.419 and 144.4195.

Subd. 2. [INFORMATION GIVEN.] ~~Where feasible,~~ Before performing examinations, testing, treatment, or vaccination of an individual under subdivision 1, a health care provider shall notify the individual of the right to refuse the examination, testing, treatment, or vaccination, and the consequences, including isolation or quarantine, upon refusal.

Sec. 10. Minnesota Statutes 2004, section 12.42, is amended to read:

12.42 [OUT-OF-STATE LICENSE HOLDERS; POWERS, DUTIES.]

During ~~an~~ a declared emergency ~~or disaster~~, a person who holds a license, certificate, or other permit issued by a state of the United States, the District of Columbia, or a province of Canada evidencing the meeting of qualifications for professional, mechanical, or other skills, may render aid involving those skills in this state when such aid is requested by the governor to meet the needs of the emergency. The license, certificate, or other permit of the person, while rendering aid, has the same force and effect as if issued in this state, subject to such limitations and conditions as the governor may prescribe.

Sec. 11. [12.61] [HOSPITAL OR MEDICAL TRANSPORT CAPACITIES EXCEEDED; RESPONDER LIABILITY LIMITATION.]

Subdivision 1. [DEFINITIONS.] For purposes of this section:

(1) "emergency plan" includes:

(i) any plan for managing an emergency threatening public health developed by the commissioner of health or a local public health agency;

(ii) any plan for managing an emergency threatening public health developed by one or more hospitals, clinics, nursing homes, or other health care facilities or providers and approved by the commissioner of health or local public health agency in consultation with emergency management officials; or

(iii) any provision for assistance by out-of-state responders under interstate or international compacts, including but not limited to the Emergency Management Assistance Compact.

Emergency plans shall, so far as practicable, include

provisions for protecting children, persons with disabilities, and persons with limited English proficiency;

(2) "regional hospital system" means all hospitals in one of the hospital bioterrorism preparedness program geographic regions of the state set forth in the most recent hospital preparedness plan available on the Department of Health Web site at www.health.state.mn.us/oep; and

(3) "responder" means any person or organization that provides health care or other health-related services in an emergency including, but not limited to, physicians, physician assistants, registered and other nurses, certified nursing assistants, or other staff within a health care provider organization, pharmacists, chiropractors, dentists, emergency medical technicians, members of a specialized medical response unit, laboratory technicians, morticians, registered first responders, mental health professionals, hospitals, nursing and boarding care facilities, home health care agencies, other long-term care providers, medical and dental clinics, and medical laboratories and including, but not limited to, ambulance service personnel and dispatch services and persons not registered as first responders but affiliated with a medical response unit and dispatched to the scene of an emergency by a public safety answering point or licensed ambulance service.

Subd. 2. [EMERGENCY EXECUTIVE ORDER.] (a) During a national security emergency or a peacetime emergency declared under section 12.31, the governor may issue an emergency executive order upon finding that the number of seriously ill or injured persons exceeds the emergency hospital or medical transport capacity of one or more regional hospital systems and that care for those persons has to be given in temporary care facilities.

(b) During the effective period of the emergency executive order, a responder in any impacted region acting consistent with emergency plans is not liable for any civil damages or administrative sanctions as a result of good-faith acts or omissions by that responder in rendering emergency care, advice,

or assistance. This section does not apply in case of malfeasance in office or willful or wanton actions.

Sec. 12. Minnesota Statutes 2004, section 13.3806, subdivision 1a, is amended to read:

Subd. 1a. [DEATH INVESTIGATION DATA.] Data gathered by the commissioner of health to identify the body of a person believed to have died due to a ~~public health~~ declared emergency as defined in section 12.03, subdivision ~~9a~~ 1e, the circumstances of death, and disposition of the body are classified in and may be released according to section 12.381, subdivision 2.

Sec. 13. Laws 2002, chapter 402, section 21, as amended by Laws 2004, chapter 279, article 11, section 7, is amended to read:

Sec. 21. [SUNSET.]

Sections 1 ~~to 19~~, 2, 5, 8, 10, and 11 expire August 1, 2005.

Sec. 14. [EFFECTIVE DATE.]

Section 13 is effective the day following final enactment.

Senator ..... moves to amend S.F. No. 1483 as follows:

Page 2, delete line 5

Page 2, line 6, delete "indemnification"

Page 2, line 10, delete everything after "state" and insert a period

Page 2, delete line 11

Page 7, line 1, after the first comma, insert "the elderly,"

~~Page 8, line 15, delete "and" and after "11" insert ", 17, 18, and 19"~~

Policy Position

Minnesota Department of Health

March 22, 2005

All Hazard Emergency Response

SF 1483 HF 1555

Minnesota All Hazard Emergency Response

All Hazard Emergency Response proposes a common set of tools that can be used for a variety of disasters. Chapter 12 is the Emergency Management Act that guides Minnesota's preparedness for, response to, and recovery from all disasters; irrespective of their origin and type. This proposal updates and strengthens the provisions of Chapter 12 that enable state and local government to protect life, property, and health.

Background

The 2002 legislature enacted the Minnesota Emergency Health Powers Act, which addressed the emergency preparedness powers of state and local government in light of the terrorist attacks of 2001. The 2004 legislature extended the sunset for these powers to August 2005.

The Emergency Health Powers Act directed the Minnesota Department of Health to study and report on further legislative needs. The report recommended planning and exercises, working with the Department of Public Safety, and seeking input from local public health and other emergency responders. Those efforts have demonstrated the need for an "**all hazard**" approach to emergency planning and response.

The all hazard strategy provides a coordinated approach to a wide variety of incidents, including floods, tornadoes, environmental exposures, terrorist events, and disease outbreaks. All responders use a similar, coordinated approach with a common set of authorities, protections, and resources.

MINNESOTA MDH DEPARTMENT OF HEALTH

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Current emergency provisions to be continued

Chapter 12 is state government's basic framework for responding to an emergency event. It authorizes rapid action, requires coordination of effort, and includes checks and balances to assure that powers are used appropriately. Changes made in 2002 specifically addressed issues that might arise during an infectious disease outbreak, including the right to refuse examination and treatment, the sharing of medical supplies, safe management of the deceased, and restrictions on transportation or movement of people. These changes are important to many kinds of disasters. They should be continued and applied to all hazards.

Proposed changes

1. **Eliminate specific references to "public health emergency"** in Chapter 12, and integrate provisions pertaining to a public health emergency into existing emergency management law.
2. Authorize professionals licensed in **Canada and Washington, D.C. to assist** in a Minnesota emergency as the Governor requests.
4. **Extend "Good Samaritan" style liability protections** to all responders in worst-case situations where the capacity of the health care system has been exceeded.

Who is affected?

All Minnesotans are potentially affected by an emergency. Previous experience has shown that clarity of roles and responsibilities is critical during an emergency – crucial to protecting lives and property, and sustaining the economy. Recent examples include SARS in Toronto, the Monkeypox outbreak of 2003,

(OVER)

the anthrax attacks of 2001, chemical spills, and tornadoes.

Hospitals, physicians and other health care and emergency providers will have liability protection when a disaster overwhelms the health care system and hospital capacity is exceeded, so long as they act in good faith and in accord with formally adopted emergency plans.

During a disaster or emergency, **volunteers** will have the liability and workers compensation protections normally afforded to a government employee, if they are registered with and acting under the authority of state or local government. These protections will make it easier for skilled volunteers to be part of the response.

Local and state government personnel can better prepare for all kinds of emergencies using a common set of tools.

What are the consequences if this legislation does not pass?

1. Recruiting volunteers and mobilizing emergency responders will be more difficult without clear provisions regarding liability and workers compensation

2. The right to refuse testing and treatment during an emergency will not be clearly defined or described.

3. Fears about liability may make it more difficult to recruit and retain an adequate number of responders when the volume of ill or injured patients makes it impossible to sustain usual standards of care.

4. It will not be possible to use the services of Canadian health care workers during an emergency.

Individuals and groups providing input to date:

Task Force on Terrorism and Health
Homeland Security Advisory Committee
State Com. Health Services Adv. Committee
Minnesota Local Public Health Association
Minnesota Hospital Association
Minnesota Medical Association
Minnesota Board of Medical Practice
Minnesota Dental Association
County Attorney's Association
Minnesota Council of Health Plans
Minnesota Public Health Association
Association of Minnesota Counties
Department of Public Safety
Ramsey County Court Administrator
Minnesota Business Partnership
Minnesota Chamber of Commerce
Minnesota Board of Nursing
Minnesota Ambulance Association
Minnesota Nurses Association

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Director

Senate
State of Minnesota

S.F. No. 65 - Health Care
(Delete-Everything Amendment - SCS0065A-2)

Author: Senator Linda Berglin

Prepared by: Katie Cavanor, Senate Counsel (651/296-3801) KC

Date: March 22, 2005

S.F. No. 65 makes a number of modifications to the public health care programs.

Section 1 (62A.65) requires the Commissioners of Commerce and Health to apply the premium growth limits established under Minnesota Statutes, section 62J.04, subdivision 1b, when approving the individual market rates.

Section 2 (62D.12, subdivision 19) permits a health maintenance organization to deny or limit coverage for services requiring prior authorization under public health care programs.

Section 3 (62J.04, subdivision 1b) requires the Commissioner of Health to establish premium growth limits for health plan companies.

Paragraph (a) states that for calendar years 2005 to 2010 the premium limits shall be set at Consumer Price Index (CPI) for urban consumers for the preceding calendar year plus two percent. An additional one percentage point shall be added to be used to finance the implementation of the electronic medical record system. The commissioner is required to ensure that the additional percentage point is being used to provide financial assistance to health care providers for that purpose.

Paragraph (b) states that for calendar years beyond 2010, the premium growth limits shall be set at CPI for urban consumers plus two percent. The Commissioners of Health and Commerce shall make a recommendation to the Legislature on whether to continue the additional percentage point described in **paragraph (a)**.

Paragraph (c) authorizes the commissioner to add additional percentage points if a major disaster, bioterrorism, or a public health emergency event occurs that effects heath care costs.

Paragraph (d) requires the commissioner to publish the annual premium growth limits in the *State Register* by January 31 of the year that the limits are to be in effect.

Paragraph (e) states that premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Requires premium growth rates to be calculated for the individual, small group, and large group lines of business.

Paragraph (f) clarifies that this section applies to employee health plans offered by self-insured employers.

Paragraph (g) requires the Commissioner of Employee Relations to direct contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations.

Section 4 (62J.04, subdivision 3) authorizes the commissioner to use the data collected to be used to monitor the achievement of premium growth limits.

Section 5 (62J.041) requires the Commissioner of Health to establish annual health care expenditure limits not to exceed the premium limits. Defines "health care expenditures" as incurred claims or expenditures on health care services. Requires the commissioner to publish in the *State Register* and make available to the public by July 1, 2007, and each year thereafter a list of all health plan companies that exceeded their health care expenditure limit for the previous calendar year.

Section 6 (62J.255) requires health plan companies to provide educational information to enrollees on the increased personal health risks and the additional cost to the health care system due to obesity and due to smoking. It also requires the Commissioner of Health, in consultation with the Minnesota Medical Association (MMA), to develop an information sheet on the personal health risks and on the additional costs to the health care system associated with obesity and on smoking.

Section 7 (62J.301, subdivision 3) requires the commissioner to collect and maintain data for the purposes of setting premium growth limits and measuring compliance.

Section 8 (62J.38) requires the cost containment data to be broken down to distinguish between the individual market, the small group market, and the large group market.

Section 9 (62J.692, subdivision 3) states that a clinical medical education program that trains pediatricians is requested to include in their program curriculum training in case management and medication management for children suffering from mental illness in order to eligible for MERC funds.

Section 10 (62L.08, subdivision 8) requires the Commissioners of Health and Commerce to apply the premium growth limits established under section 62J.04, subdivision 1b, when approving the small employer market rates.

Section 11 (62Q.175) states that no health plan company is required to cover any health care service included in the list established under section 256B.0625, subdivision 46.

Sections 12 and 13 (144.1501) extends the loan forgiveness program to medical residents who are specializing in the area of pediatric psychiatry.

Section 14 (256.045, subdivision 3a) states that on appeal, the referee may not overturn a decision on prior authorization for services requiring prior authorization if the prepaid health plan has appropriately used evidence-based criteria or guidelines in making its determination.

Section 15 (256.9545) reinstates the Prescription Drug Discount Program (which expired upon the effective date of an expanded prescription drug benefit under Medicare) and makes changes to the program by eliminating the income limit on eligibility, making individuals who are enrolled in Medicare ineligible, and changing the administration fee to an enrollment fee of $100.

Section 16 (256.9693) extends the continuing care program for persons with mental illness to persons with mental illness who are eligible for general assistance medical care.

Section 17 (256B.0625, subdivision 3b) extends coverage of telemedicine consultations to include telephone conversations between a pediatrician and a psychiatrist when the consultation is for the purpose of managing the medications of a child with mental health needs.

Section 18 (256B.0625, subdivision 46) requires the commissioner, in consultation with the Commissioner of Health, to biennially develop a list of services that are not eligible for reimbursement under chapters 256B, 256D, and 256L effective for services provided on or after July 1, 2007. The commissioner must review the list in effect for the prior biennium and make any additions or deletions from the list as appropriate. The commissioner may convene an ad hoc panel to assist the commissioner in reviewing and establishing the list. The commissioner must solicit comments and recommendations from the public through public hearings. The initial list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, and must be published in the *State Register* by November 1 of the even-numbered years beginning November 1, 2008. The commissioner must submit the list to the Legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Section 19 (256B.0627, subdivision 1) modifies several definitions in the statute outlining home care covered services. It prohibits assessments of client needs from being conducted by the entity providing the services. It places restrictions on the delegation of authority by a responsible party to another person.

Section 20 (256B.0627, subdivision 4) prohibits certain relatives from providing personal care assistant (PCA) services to recipients unless hardship criteria are satisfied and DHS approves the arrangement. This section also requires DHS to establish an ongoing effort to uncover potential fraud and abuse int eh PCA program.

Section 21 (256B. 0627, subdivision 9) authorizes the flexible use of PCA house only if allowed by DHS. It establishes requirements for determining whether flexible use of hours is an appropriate

option for a recipient. Its authorizes DHS to deny, revoke, or suspend the authorization for flexible use of hours if program requirements are not met.

Section 22 (256B.0631, subdivision 5), states that the medical assistance co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program.

Section 23 (256B.072), paragraph (a), requires the commissioner to establish a performance reporting and payment system for providers who provide services to public program recipients.

Paragraph (b) establishes the measures that are to be used for the reporting and payment system.

Paragraph (c) requires the commissioner to provide a performance bonus payment to providers who have met certain levels of performance established by the commissioner.

Paragraph (d) states the performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

Paragraph (e) requires the commissioner to publish a description of the proposed performance reporting and payment system for the calendar year beginning January 1, 2007, and each subsequent calendar year at least three months before the beginning of that calendar year.

Paragraph (f) requires the commissioner to report annually through a public Web site the results by medical group, single-physician practice, and hospital of the measures and performance payments under this section and shall compare the results for patients enrolled in public programs with those enrolled in private health plans.

Section 24 (256B.0918) provides a rate increase of two-tenths of one percent to specified providers for employee scholarships and job-related training in English as a second language. Eligible provider groups are listed and include all waivered services providers, personal care service providers, home health service providers, day training and habilitation services, etc.

Section 25 (256D.03, subdivision 4) states that the GAMC co-payments shall be waived by the provider if the recipient is practicing a healthy lifestyle by reforming from tobacco use or if participating in a smoking cessation program.

Section 26 (256L.07, subdivision 1) reinstates the ability of individuals and families to remain on MinnesotaCare if their income increases over the maximum income eligibility level but is less than ten percent of the annual premium for a policy with a $500 deductible available through MCHA.

Section 27 (256L.20) establishes the MinnesotaCare option for small employers.

Subdivision 1 defines the following terms: "dependent," "eligible employer," "eligible employee," "maximum premium," "participating employer," and "program."

Subdivision 2 authorizes enrollment in MinnesotaCare coverage for all eligible employees and their dependents, if the eligible employer meets the requirements of subdivision 3.

Subdivision 3 states that to participate an eligible employer must: (1) agree to contribute toward the cost of the premium for the employee and the employee's dependents; (2) certify that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program; (3) offer coverage to all eligible employees and the dependents of those employees; and (4) not have provided employer-subsidized health coverage as an employee benefit during the previous 12 months.

Subdivision 4 requires the employer to pay 50 percent of the maximum premium for eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines (FPG) and for eligible employees with dependents with income equal to or less than 275 percent of FPG. States that for eligible employees without dependents with income over 175 percent of FPG and eligible employees with dependents with income over 275 percent of FPG, the employer must pay the full cost of the maximum premium. Permits employer to require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the total cost. If the employee is required to pay a portion of the premium, the payment shall be made to the employer. Requires the commissioner to collect the premiums from the participating employers.

Subdivision 5 states that the coverage provided shall be the MinnesotaCare covered services with all applicable co-pays and coinsurance.

Subdivision 6 states that upon the payment of the premium eligible employees and their dependents shall be enrolled in the MinnesotaCare program. States that the insurance barrier of section 256L.07, subdivisions 2 and 3, do not apply. Authorizes the commissioner to require eligible employees to provide income verification to determine premiums.

Section 28 lists a number of services that will require prior authorization for reimbursement in the public program effective July 1, 2005. This section also requires that a technology assessment be conducted by an independent organization before any new medical device, brand drug, or medical procedure is included in the covered services for public programs.

Section 29 requires the Commissioner of Health, in consultation with the Commissioners of Human Services and Education, to convene a task force to study and make recommendations on reducing the rate of obesity among children in Minnesota. Requires the task force to set a goal in terms of reducing the rate of childhood obesity and make recommendations as to how to achieve the goal, including increasing the physical education activities, improving the nutritional offerings, exploring opportunities to promote physical education and healthy eating programs, and evaluating the availability and choice

of nutritional products offered within the schools. States the make up of the task force. Requires that these recommendations be submitted to the Legislature by January 15, 2007.

Section 30 requires the Commissioner of Health, in consultation with the electronic health records planning work group, to develop a statewide plan for all hospitals ands physician group practices to have in place an interoperable electronic health records system by January 1, 2015.

Section 31 appropriates money: a blank amount to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan; and a blank amount to the Commissioner of Health for the loan forgiveness program.

KC:ph

Senators Berglin and Tomassoni introduced--

S.F. No. 65: Referred to the Committee on Health and Family Security.

A bill for an act

relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; providing for an electronic medical record system; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; authorizing the sale of bonds; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.43; 62J.692, subdivision 3; 62L.08, subdivision 8; 144.1501, subdivisions 2, 4; 256.955, subdivisions 2a, 2b, 3, 4, 6; 256.9693; 256B.03, subdivision 3; 256B.061; 256B.0625, subdivisions 3b, 9, 13e, by adding a subdivision; 256B.0631, by adding a subdivision; 256B.075, subdivisions 1, 2, 3; 256D.03, subdivisions 3, 4; 256L.03, subdivision 1; 256L.05, subdivision 4; 256L.07, subdivision 1; 256L.12, subdivision 6; Laws 2003, First Special Session chapter 14, article 6, section 65; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L; repealing Minnesota Statutes 2004, sections 256.955, subdivision 4a; 256B.075, subdivision 5; 256L.035.

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

Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata

for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(4) the health carrier provides actuarial justification

acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) Notwithstanding paragraphs (a) to (g), the rates must not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62J.04, is

amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month

premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company," has the meaning given in section 62J.041.

(g) For coverage that is provided by a health plan company under the terms of a contract with the Department of Employee Relations, the commissioner of employee relations shall direct the contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 3. Minnesota Statutes 2004, section 62J.04, subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

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

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

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

(4) issue recommendations regarding uniform billing forms, uniform electronic billing procedures and data interchanges, patient identification cards, and other uniform claims and administrative procedures for health care providers and private and public sector payers. In developing the recommendations,

the commissioner shall review the work of the work group on electronic data interchange (WEDI) and the American National Standards Institute (ANSI) at the national level, and the work being done at the state and local level. The commissioner may adopt rules requiring the use of the Uniform Bill 82/92 form, the National Council of Prescription Drug Providers (NCPDP) 3.2 electronic version, the Centers for Medicare and Medicaid Services 1500 form, or other standardized forms or procedures;

(5) undertake health planning responsibilities;

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

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

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

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

Sec. 4. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM~~ HEALTH PLAN COMPANY ~~COST-CONTAINMENT GOALS~~ HEALTH CARE 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 and also includes employee health plans offered by self-insured employers.

(c) "~~Total~~ Health care 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, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost containment goals~~ health care expenditure limits for ~~the increase in net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for calendar years 1994, 1995, 1996, and 1997. The cost containment goals must be the same as the annual cost containment goals for health care spending established under section 62J.04, subdivision 1, paragraph (b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost containment goal~~ health care expenditure limit. The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

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~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this

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

Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

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

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

(d) Health plan companies in paragraph (c) whose reserves are less than the required minimum or more than the required maximum at the end of the fiscal year shall submit a plan of

corrective action to the commissioner of health or commerce under subdivision 7.

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

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment-goal~~ health care expenditure limit for the ~~1994~~ previous calendar year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost-containment-goal,~~ health care 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 ~~cost-containment-goal~~ health care 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.

Sec. 5. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

Sec. 6. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

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

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

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium 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.

Sec. 7. Minnesota Statutes 2004, section 62J.38, is amended to read:

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. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care;

underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local, state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

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

(2) prices, provider experience, and other information for services less commonly covered by insurance or for which

patients commonly face significant out-of-pocket expenses; and

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

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

Sec. 8. Minnesota Statutes 2004, section 62J.43, is amended to read:

62J.43 [BEST PRACTICES AND QUALITY IMPROVEMENT.]

(a) To improve quality and reduce health care costs, state agencies shall encourage the adoption of best practice guidelines and participation in best practices measurement activities by physicians, other health care providers, and health plan companies. The commissioner of health shall facilitate access to best practice guidelines and quality of care measurement information to providers, purchasers, and consumers by:

(1) identifying and promoting local community-based, physician-designed best practices care across the Minnesota health care system;

(2) disseminating information available to the commissioner on adherence to best practices care by physicians and other health care providers in Minnesota;

(3) educating consumers and purchasers on how to effectively use this information in choosing their providers and in making purchasing decisions; and

(4) making best practices and quality care measurement information available to enrollees and program participants through the Department of Health's Web site. The commissioner may convene an advisory committee to ensure that the Web site is designed to provide user friendly and easy accessibility.

(b) The commissioner of health shall collaborate with a nonprofit Minnesota quality improvement organization specializing in best practices and quality of care measurements to provide best practices criteria and assist in the collection

of the data.

(c) The initial best practices and quality of care measurement criteria developed shall include asthma, diabetes, and at least two other preventive health measures. Hypertension and coronary artery disease shall be included within one year following availability.

(d) The commissioners of human services and employee relations ~~may~~ shall use the data to make decisions about contracts they enter into with health plan companies and shall establish payment withholds based on best practices and quality of care measurements as part of the contracts in effect January 1, 2007. The health plan companies may pass the withholds through to physicians and other health care providers if the physician or health care provider fails to follow the best practices and quality of care measurement criteria identified in this section. The withholds established by the commissioner of human services shall be included with the withholds described in sections 256B.69, subdivision 5a, and 256L.12, subdivision 9. If a payment withhold is passed through, a provider may not terminate an existing contract with a health plan company based solely on this withhold.

(e) This section does not apply if the best practices guidelines authorize or recommend denial of treatment, food, or fluids necessary to sustain life on the basis of the patient's age or expected length of life or the patient's present or predicted disability, degree of medical dependency, or quality of life.

(f) The commissioner of health, human services, and employee relations shall report to the legislature by January 15, 2005, on the status of best practices and quality of care initiatives, and shall present recommendations to the legislature on any statutory changes needed to increase the effectiveness of these initiatives.

~~(g) This section expires June 30, 2006.~~

Sec. 9. [62J.565] [IMPLEMENTATION OF ELECTRONIC MEDICAL RECORD SYSTEM.]

(a) By January 1, 2010, all hospitals and health care providers must have in place an electronic medical record system within their hospital system or clinical practice setting. The commissioner may grant exemptions from this requirement if the commissioner determines that the cost of compliance would place the provider in financial distress or if the commissioner determines that appropriate technology is not available or advantageous to that type of practice. Before an exemption is granted for financial reasons, the commissioner must ensure that the provider has explored all possible alliances or partnerships with other provider groups in the provider's geographical area to become part of the larger provider group's system.

(b) The commissioner shall provide assistance to hospitals and provider groups in establishing an electronic medical record system, including, but not limited to, provider education, facilitation of possible alliances or partnerships among provider groups for purposes of implementing a system, identification or establishment of low-interest financing options for hardware and software, and systems implementation support.

(c) The commissioner of human services shall convene an advisory committee with representatives of safety-net hospitals, community health clinics, and other providers who serve low-income patients to address their specific needs and concerns regarding the establishment of an electronic medical record system within their hospital or practice setting. As part of addressing the specific needs of these providers, the commissioner shall explore the implementation of an accessible interactive system created collaboratively by publicly owned hospitals and clinics. The commissioner shall also explore financial assistance options, including bonding and federal grants.

Sec. 10. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical education program conducted in Minnesota by a teaching

institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

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

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

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

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

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

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

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

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

(3) for each clinical medical education program for which funds are being sought; the type and specialty orientation of trainees in the program; the name, site address, and medical

assistance provider number of each training site used in the program; the total number of trainees at each training site; and the total number of eligible trainee FTEs at each site. Only those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

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

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

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

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

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

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

Sec. 11. [62J.82] [ELECTRONIC MEDICAL RECORD SYSTEM LOAN PROGRAM.]

Subdivision 1. [ESTABLISHMENT.] The commissioner shall establish and implement a loan program to help physicians or physician group practices obtain the necessary finances to install an electronic medical record system.

Subd. 2. [RULES.] The commissioner may adopt rules to administer the loan program.

Subd. 3. [ELIGIBILITY.] To be eligible for a loan under this section, the borrower must:

(1) have a signed contract with a vendor;

(2) be a physician licensed in this state or a physician group practice located in this state;

(3) provide evidence of financial stability;

(4) demonstrate an ability to repay the loan;

(5) demonstrate that the borrower has explored possible alliances or contractual opportunities with other provider groups located in the same geographical area to become part of the larger provider group's system; and

(6) meet any other requirement the commissioner imposes by administrative procedure or by rule.

Subd. 4. [LOANS.] (a) The commissioner may make a direct loan to a provider or provider group who is eligible under subdivision 3. The total accumulative loan principal must not exceed $65,000 per loan.

(b) The commissioner may prescribe forms and establish an application process and, notwithstanding section 16A.1283, may impose a reasonable nonrefundable application fee to cover the cost of administering the loan program.

(c) Loan principal balance outstanding plus all assessed interest must be repaid no later than 15 years from the date of the loan.

Sec. 12. [62J.83] [ELECTRONIC MEDICAL RECORD SYSTEM LOAN FUND.]

Subdivision 1. [CREATION.] The electronic medical record system loan fund is established as a special account in the state treasury. All application fees, loan repayments, and other revenue received under section 62J.82 must be credited to the fund.

Subd. 2. [BOND PROCEEDS ACCOUNT.] An electronic medical record system revenue bond proceeds account is established in the electronic medical record system loan fund. The proceeds of any bonds issued under section 62J.84 must be credited to the account. Money in the account is appropriated to the commissioner to make loans under section 62J.82.

Subd. 3. [DEBT SERVICE ACCOUNT.] An electronic medical

record system revenue bond debt service account is established in the electronic medical record system loan fund. There must be credited to this debt service account in each fiscal year from the income to the electronic medical record system loan fund an amount sufficient to increase the balance on hand in the debt service account on each December 1 to an amount equal to the full amount of principal and interest to come due on all outstanding bonds issued under section 62J.84 to and including the second following July 1. The assets of the account are pledged to and may only be used to pay principal and interest on bonds issued under section 62J.84. Money in the debt service account is appropriated to the commissioner of finance to pay principal and interest on bonds issued under section 62J.84.

Subd. 4. [APPROPRIATION.] Money in the electronic medical record system loan fund not otherwise appropriated is appropriated to the commissioner to administer the loan program.

Sec. 13. [62J.84] [ELECTRONIC MEDICAL RECORD SYSTEM REVENUE BONDS.]

Subdivision 1. [BONDING AUTHORITY.] Upon request of the commissioner, the commissioner of finance may sell and issue state revenue bonds to make loans under section 62J.82, to establish a reserve fund or funds, and to pay the cost of issuance of the bonds.

Subd. 2. [AMOUNT.] The principal amount of the bonds issued for the purposes specified in subdivision 1 must not exceed $5,000,000.

Subd. 3. [PROCEDURE.] The commissioner may sell and issue the bonds on the terms and conditions the commissioner determines to be in the best interests of the state. The bonds may be sold at public or private sale. The commissioner may enter any agreements or pledges the commissioner determines necessary or useful to sell the bonds that are not inconsistent with sections 62J.82 to 62J.84. Sections 16A.672 to 16A.675 apply to the bonds.

Subd. 4. [REVENUE SOURCES.] The bonds are payable only from the following sources:

(1) loan repayments credited to the electronic medical record system loan fund;

(2) the principal and any investment earnings on the assets of the debt service account; and

(3) other revenues pledged to the payment of the bonds.

Subd. 5. [REFUNDING BONDS.] The commissioner may issue bonds to refund outstanding bonds issued under subdivision 1, including the payment of any redemption premiums on the bonds and any interest accrued or to accrue to the first redemption date after delivery of the refunding bonds. The proceeds of the refunding bonds may, in the discretion of the commissioner, be applied to the purchases or payment at maturity of the bonds to be refunded, or the redemption of the outstanding bonds on the first redemption date after delivery of the refunding bonds and may, until so used, be placed in escrow to be applied to the purchase, retirement, or redemption. Refunding bonds issued under this subdivision must be issued and secured in the manner provided by the commissioner.

Subd. 6. [NOT A GENERAL OR MORAL OBLIGATION.] Bonds issued under this section are not public debt, and the full faith, credit, and taxing powers of the state are not pledged for their payment. The bonds may not be paid directly in whole or part from a tax of statewide application on any class of property, income, transaction, or privilege. Payment of the bonds is limited to the revenues explicitly authorized to be pledged under this section. The state neither makes nor has a moral obligation to pay the bonds if the pledged revenues and other legal security for them is insufficient.

Subd. 7. [TRUSTEE.] The commissioner may contract with and appoint a trustee for bondholders. The trustee has the powers and authority vested in it by the commissioner under the bond and trust indentures.

Subd. 8. [PLEDGES.] Any pledge made by the commissioner is valid and binding from the time the pledge is made. The money or property pledged and later received by the commissioner is immediately subject to the lien of the pledge without any

physical delivery of the property or money or further act, and the lien of any pledge is valid and binding as against all parties having claims of any kind in tort, contract, or otherwise against the commissioner, whether or not those parties have notice of the lien or pledge. Neither the order nor any other instrument by which a pledge is created need be recorded.

Subd. 9. [BONDS; PURCHASE AND CANCELLATION.] The commissioner, subject to agreements with bondholders that may then exist, may, out of any money available for the purpose, purchase bonds of the commissioner at a price not exceeding:

(1) if the bonds are then redeemable, the redemption price then applicable plus accrued interest to the next interest payment date thereon; or

(2) if the bonds are not redeemable, the redemption price applicable on the first date after the purchase upon which the bonds become subject to redemption plus accrued interest to that date.

Subd. 10. [STATE PLEDGE AGAINST IMPAIRMENT OF CONTRACTS.] The state pledges and agrees with the holders of any bonds that the state will not limit or alter the rights vested in the commissioner to fulfill the terms of any agreements made with the bondholders, or in any way impair the rights and remedies of the holders until the bonds, together with interest on them, with interest on any unpaid installments of interest, and all costs and expenses in connection with any action or proceeding by or on behalf of the bondholders, are fully met and discharged. The commissioner may include this pledge and agreement of the state in any agreement with the holders of bonds issued under this section.

Sec. 14. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating

restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

(b) Notwithstanding paragraph (a), the rates shall not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.~~

Sec. 15. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 16. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities~~,~~ or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas~~,~~ or to teach for at least 20 hours per week in the nursing field in a postsecondary program; and

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions or to teach for at least 20 hours per week in the nursing field in a postsecondary program; and

(4) for other health care technicians agreeing to teach for at least 20 hours per week in their designated field in a postsecondary program. The commissioner, in consultation with the Healthcare Education-Industry Partnership, shall determine the health care fields where the need is the greatest, including, but not limited to, respiratory therapy, clinical laboratory technology, radiologic technology, and surgical technology.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing commitments shall cancel to the fund.

Sec. 17. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or teaching area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that ~~75~~ 50 percent of the funds available are used for rural physician loan forgiveness ~~and~~, 25 percent of the funds available are used for underserved urban communities loan forgiveness, and 25 percent of the funds available are used for pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may

be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 18. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all

manufacturers of covered drugs as defined in section 256B.0625, subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible

for the program under subdivision 4 and has enrolled in the program according to subdivision 5.

Subd. 4. [ELIGIBLE PERSONS.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, MinnesotaCare, or the prescription drug program under section 256.955;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage 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 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating

pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section; to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Sec. 19. Minnesota Statutes 2004, section 256.955, subdivision 2a, is amended to read:

Subd. 2a. [ELIGIBILITY.] An individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription

drug program:

(1) is at least 65 years of age or older; ~~and~~

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a, or is eligible under section 256B.057, subdivision 3 or 3a, and is also eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5; and

(3) applies for the Medicare-endorsed drug discount card and for transitional assistance, if eligible.

Sec. 20. Minnesota Statutes 2004, section 256.955, subdivision 2b, is amended to read:

Subd. 2b. [ELIGIBILITY.] Effective July 1, 2002, an individual satisfying the following requirements and the requirements described in subdivision 2, paragraph (d), is eligible for the prescription drug program:

(1) is under 65 years of age; ~~and~~

(2) is eligible as a qualified Medicare beneficiary according to section 256B.057, subdivision 3 or 3a or is eligible under section 256B.057, subdivision 3 or 3a and is also eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5; and

(3) applies for the Medicare-endorsed drug discount card and for transitional assistance, if eligible.

Sec. 21. Minnesota Statutes 2004, section 256.955, subdivision 3, is amended to read:

Subd. 3. [PRESCRIPTION DRUG COVERAGE.] Coverage under the program shall be limited to those prescription drugs that:

(1) are covered under the medical assistance program as described in section 256B.0625, subdivision 13;

(2) are provided by manufacturers that have fully executed ~~senior~~ prescription drug program rebate agreements with the commissioner and comply with such agreements; and

(3) for a specific enrollee, are not covered under ~~an assistance-program-offered-by-a-pharmaceutical-manufacturer,-as determined-by-the-board-on-aging-under-section-256.975, subdivision-9,-except-that-this-shall-not-apply-to-qualified~~

~~individuals under this section who are also eligible for medical assistance with a spenddown as described in subdivisions 2a, clause (2), and 2b, clause (2).~~ a Medicare-endorsed drug discount card transitional assistance unless:

(i) the prescription drug is not included in the Medicare-endorsed discount card plan formulary but is covered under the prescription drug program;

(ii) the cost of a prescription drug is more than the remaining Medicare-endorsed drug discount card transitional assistance; or

(iii) a prescribed over-the-counter medication is not included in the Medicare-endorsed drug discount card plan formulary but is covered under the prescription drug program.

Sec. 22. Minnesota Statutes 2004, section 256.955, subdivision 4, is amended to read:

Subd. 4. [APPLICATION PROCEDURES AND COORDINATION WITH MEDICAL ASSISTANCE AND MEDICARE-ENDORSED DRUG DISCOUNT CARD.]

(a) Applications and information on the program must be made available at county social service agencies, health care provider offices, and agencies and organizations serving senior citizens and persons with disabilities. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the county social service agencies:

(1) beginning January 1, 1999, the county social service agency shall determine medical assistance spenddown eligibility of individuals who qualify for the prescription drug program; and

(2) program payments will be used to reduce the spenddown obligations of individuals who are determined to be eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5.

(b) Qualified individuals who are eligible for medical assistance with a spenddown shall be financially responsible for the deductible amount up to the satisfaction of the spenddown. No deductible applies once the spenddown has been met. Payments

to providers for prescription drugs for persons eligible under this subdivision shall be reduced by the deductible.

(c) County social service agencies shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Eligibility begins the month after approval.

(d) Enrollees who are also enrolled in the Medicare-endorsed drug discount card plan and for transitional assistance must obtain prescription drugs at a pharmacy enrolled as a provider for both the Medicare-endorsed drug discount plan and the prescription drug program.

Sec. 23. Minnesota Statutes 2004, section 256.955, subdivision 6, is amended to read:

Subd. 6. [PHARMACY REIMBURSEMENT.] The commissioner shall reimburse participating pharmacies for drug and dispensing costs at the medical assistance reimbursement level, minus the deductible required under subdivision 7. The commissioner shall not reimburse enrolled pharmacies until the Medicare-endorsed drug discount card transitional assistance has been exhausted, unless the exceptions in subdivision 3, clause (3), are met.

Sec. 24. Minnesota Statutes 2004, section 256.9693, is amended to read:

256.9693 [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance or general assistance medical care may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under

section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

Sec. 25. Minnesota Statutes 2004, section 256B.03, subdivision 3, is amended to read:

Subd. 3. [TRIBAL PURCHASING MODEL.] (a) Notwithstanding subdivision 1 and sections 256B.0625 and 256D.03, subdivision 4, paragraph ~~(i)~~ (h), the commissioner may make payments to federally recognized Indian tribes with a reservation in the state to provide medical assistance and general assistance medical care to Indians, as defined under federal law, who reside on or near the reservation. The payments may be made in the form of a block grant or other payment mechanism determined in consultation with the tribe. Any alternative payment mechanism agreed upon by the tribes and the commissioner under this subdivision is not dependent upon county or health plan agreement but is intended to create a direct payment mechanism between the state and the tribe for the administration of the medical assistance and general assistance medical care programs, and for covered services.

(b) A tribe that implements a purchasing model under this subdivision shall report to the commissioner at least annually on the operation of the model. The commissioner and the tribe

shall cooperatively determine the data elements, format, and timetable for the report.

(c) For purposes of this subdivision, "Indian tribe" means a tribe, band, or nation, or other organized group or community of Indians that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians and for which a reservation exists as is consistent with Public Law 100-485, as amended.

(d) Payments under this subdivision may not result in an increase in expenditures that would not otherwise occur in the medical assistance program under this chapter or the general assistance medical care program under chapter 256D.

Sec. 26. Minnesota Statutes 2004, section 256B.061, is amended to read:

256B.061 [ELIGIBILITY; RETROACTIVE EFFECT; RESTRICTIONS.]

(a) If any individual has been determined to be eligible for medical assistance, it will be made available for care and services included under the plan and furnished in or after the third month before the month in which the individual made application for such assistance, if such individual was, or upon application would have been, eligible for medical assistance at the time the care and services were furnished. The commissioner may limit, restrict, or suspend the eligibility of an individual for up to one year upon that individual's conviction of a criminal offense related to application for or receipt of medical assistance benefits.

(b) On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) has gross income less than 90 percent of the applicable income standard;

(2) has total liquid assets less than 90 percent of the asset limit;

(3) does not reside in a long-term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30

days' notice of the eligibility determination or eligibility shall be terminated.

Sec. 27. Minnesota Statutes 2004, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation, unless the communication is between a pediatrician and psychiatrist for the purpose of managing the medications of a child with mental health needs. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Sec. 28. Minnesota Statutes 2004, section 256B.0625, subdivision 9, is amended to read:

Subd. 9. [DENTAL SERVICES.] ~~(a)~~ Medical assistance covers dental services. Dental services include, with prior authorization, fixed bridges that are cost-effective for persons who cannot use removable dentures because of their medical condition.

~~(b) Coverage of dental services for adults age 21 and over who are not pregnant is subject to a $500 annual benefit limit and covered services are limited to:~~

~~(1) diagnostic and preventative services;~~

~~(2) restorative services; and~~

~~(3) emergency services.~~

~~Emergency services, dentures, and extractions related to dentures are not included in the $500 annual benefit limit.~~

Sec. 29. Minnesota Statutes 2004, section 256B.0625, subdivision 13e, is amended to read:

Subd. 13e. [PAYMENT RATES.] (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs plus a fixed dispensing fee; the maximum allowable cost set by the federal government or by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner, at average wholesale price minus 11.5 percent, except that where a drug has had its wholesale price reduced as a result of the actions of the National Association of Medicaid Fraud Control Units, the estimated actual acquisition cost shall be the reduced average wholesale price, without the 11.5 percent deduction. <u>The actual acquisition cost of antihemophilic factor drugs shall be estimated at the average wholesale price minus 30 percent.</u> The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) An additional dispensing fee of $.30 may be added to

the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. The pharmacy provider will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse. Over-the-counter medications must be dispensed in the manufacturer's unopened package. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

(c) Whenever a generically equivalent product is available, payment shall be on the basis of the actual acquisition cost of the generic drug, or on the maximum allowable cost established by the commissioner.

(d) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, the average wholesale price minus five percent, or the maximum allowable cost set by the federal government under United States Code, title 42, chapter 7, section 1396r-8(e), and Code of Federal Regulations, title 42, section 447.332, or by the commissioner under paragraphs (a) to (c).

Sec. 30. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D and 256L, effective for services provided on or after July 1,

2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall solicit comments and recommendations from any interested persons and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 31. Minnesota Statutes 2004, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. [HEALTHY LIFESTYLE WAIVER.] The co-payments described in subdivision 1 shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

Sec. 32. Minnesota Statutes 2004, section 256B.075, subdivision 1, is amended to read:

Subdivision 1. [GENERAL.] The commissioner shall implement disease management and care coordination initiatives that seek

to improve patient care and health outcomes and reduce health care costs by managing the care provided to recipients with chronic conditions.

Sec. 33. Minnesota Statutes 2004, section 256B.075, subdivision 2, is amended to read:

Subd. 2. [FEE-FOR-SERVICE.] (a) The commissioner shall develop and implement a disease management program for medical assistance and general assistance medical care recipients who are not enrolled in the prepaid medical assistance or prepaid general assistance medical care programs and who are receiving services on a fee-for-service basis. The commissioner may contract with an outside organization to provide these services.

(b) The commissioner shall identify recipients with special health care diagnosis through the use of data analysis software designed to identify persons most likely to need extended or costly health care in the immediate future. Based on this identification system, the commissioner shall establish a list of care coordinators and primary care providers who are qualified to act as a care manager to coordinate the care of the patient.

(c) The commissioner shall request the identified recipients to choose a care coordinator or primary care provider from the list established in paragraph (b). The care coordinator or primary care provider shall be responsible for:

(1) establishing a care team that must include a pharmacist and any health care provider necessary to treat the specific conditions of the identified recipient;

(2) performing an initial assessment and developing an individualized care plan with input from the patient;

(3) educating the patient in self-management and the importance of adhering to the care plan;

(4) providing problem follow-up and new assessments, as needed; and

(5) adhering to evidence-based best practices care strategies.

(d) The care coordinator or primary care provider may

create incentives for a recipient to ensure cooperation and patient engagement in the care plan and management.

(e) The recipient shall be required to seek health care services related to a specific diagnosis identified in paragraph (b) from the care coordinator or primary care provider or from the providers on the recipient's care team.

(f) The commissioner shall set a cost-savings target of ten percent reduction in inpatient hospitalization and emergency room costs for fiscal year 2006. Based on the achievement of this goal, one-half of the savings shall be used as a bonus to the participating primary care providers for the following fiscal year. The bonus shall be paid on a quarterly basis and shall be based on the percentage of patients treated by the provider who have been identified by the commissioner in accordance with this subdivision.

(g) The commissioner shall seek any federal approval necessary to implement this section and to obtain federal matching funds.

Sec. 34. Minnesota Statutes 2004, section 256B.075, subdivision 3, is amended to read:

Subd. 3. [PREPAID MANAGED CARE PROGRAMS.] (a) For the prepaid medical assistance, prepaid general assistance medical care, and MinnesotaCare programs, the commissioner shall ensure that contracting health plans implement disease management programs that are appropriate for Minnesota health care program recipients and have been designed by the health plan to improve patient care and health outcomes and reduce health care costs by managing the care provided to recipients with chronic conditions.

(b) The commissioner shall require all managed care plans entering into contracts under section 256B.69 to develop and implement at least three disease management programs that will improve patient care and health outcomes for those enrollees who are at risk of or diagnosed with a chronic condition.

(c) The commissioner shall require the managed care plans to measure and report outcomes according to measurements approved by the commissioner. In determining outcome

measurements, the commissioner shall establish a baseline indicating the prevalence of each disease identified in paragraph (b) in the general population and within identified racial or ethnic groups. The managed care plan must report the number of enrollees who are at risk based on the baseline measurement; the number of enrollees who have been diagnosed with the disease; and the number of enrollees participating in the managed care plan's disease management program.

(d) The commissioner shall establish targets based on the number of enrollees who should be receiving disease management services as determined by the prevalence of the disease within the general population and the number of enrollees who are receiving disease management services. The targets must also include a specified reduction in inpatient hospitalization costs and in the progression of the chronic diseases for the enrollees identified as being at risk of or diagnosed with a chronic condition.

Sec. 35. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this

subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received, including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000;

semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 36. Minnesota Statutes 2004, section 256D.03, subdivision 3, is amended to read:

Subd. 3. [GENERAL ASSISTANCE MEDICAL CARE; ELIGIBILITY.] (a) General assistance medical care may be paid for any person who is not eligible for medical assistance under chapter 256B, including eligibility for medical assistance based on a spenddown of excess income according to section 256B.056, subdivision 5, or MinnesotaCare as defined in paragraph (b), except as provided in paragraph (c), and:

(1) who is receiving assistance under section 256D.05, except for families with children who are eligible under Minnesota family investment program (MFIP), or who is having a payment made on the person's behalf under sections 256I.01 to 256I.06; or

(2) who is a resident of Minnesota; and

(i) who has gross countable income not in excess of 75 percent of the federal poverty guidelines for the family size, using a six-month budget period and whose equity in assets is not in excess of $1,000 per assistance unit. Exempt assets, the reduction of excess assets, and the waiver of excess assets must conform to the medical assistance program in section 256B.056, subdivision 3, with the following exception: the maximum amount of undistributed funds in a trust that could be distributed to

or on behalf of the beneficiary by the trustee, assuming the full exercise of the trustee's discretion under the terms of the trust, must be applied toward the asset maximum; or

(ii) who has gross countable income above 75 percent of the federal poverty guidelines but not in excess of 175 percent of the federal poverty guidelines for the family size, using a six-month budget period, whose equity in assets is not in excess of the limits in section 256B.056, subdivision 3c, and who applies during an inpatient hospitalization.

(b) General assistance medical care may not be paid for applicants or recipients who meet all eligibility requirements of MinnesotaCare as defined in sections 256L.01 to 256L.16, and are adults with dependent children under 21 whose gross family income is equal to or less than 275 percent of the federal poverty guidelines.

(c) For applications received on or after October 1, 2003, eligibility may begin no earlier than the date of application. For individuals eligible under paragraph (a), clause (2), item (i), a redetermination of eligibility must occur every 12 months. Individuals are eligible under paragraph (a), clause (2), item (ii), only during inpatient hospitalization but may reapply if there is a subsequent period of inpatient hospitalization. Beginning January 1, 2000, Minnesota health care program applications completed by recipients and applicants who are persons described in paragraph (b), may be returned to the county agency to be forwarded to the Department of Human Services or sent directly to the Department of Human Services for enrollment in MinnesotaCare. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical care shall be available in any month during which a MinnesotaCare eligibility determination and enrollment are pending. Upon notification of eligibility for MinnesotaCare, notice of termination for eligibility for general assistance medical care shall be sent to an applicant or recipient. If all other eligibility requirements of this subdivision are met, eligibility for general assistance medical

care shall be available until enrollment in MinnesotaCare subject to the provisions of paragraph (e).

(d) The date of an initial Minnesota health care program application necessary to begin a determination of eligibility shall be the date the applicant has provided a name, address, and Social Security number, signed and dated, to the county agency or the Department of Human Services. If the applicant is unable to provide a name, address, Social Security number, and signature when health care is delivered due to a medical condition or disability, a health care provider may act on an applicant's behalf to establish the date of an initial Minnesota health care program application by providing the county agency or Department of Human Services with ~~provider identification and a temporary unique identifier for the applicant~~ the applicant's name and address. If the name and address are not available, the provider may submit provider identification and a temporary unique identifier for the applicant by the end of the next business day. The date of hospital admission shall be considered to be the application date for such requests. The applicant must complete the remainder of the application and provide necessary verification before eligibility can be determined. The county agency must assist the applicant in obtaining verification if necessary. On the basis of information provided on the completed application, an applicant who meets the following criteria shall be determined eligible beginning in the month of application:

(1) has gross income less than 90 percent of the applicable income standard;

(2) has liquid assets that total within $300 of the asset standard;

(3) does not reside in a long-term care facility; and

(4) meets all other eligibility requirements.

The applicant must provide all required verifications within 30 days' notice of the eligibility determination or eligibility shall be terminated.

(e) County agencies are authorized to use all automated

databases containing information regarding recipients' or applicants' income in order to determine eligibility for general assistance medical care or MinnesotaCare. Such use shall be considered sufficient in order to determine eligibility and premium payments by the county agency.

(f) General assistance medical care is not available for a person in a correctional facility unless the person is detained by law for less than one year in a county correctional or detention facility as a person accused or convicted of a crime, or admitted as an inpatient to a hospital on a criminal hold order, and the person is a recipient of general assistance medical care at the time the person is detained by law or admitted on a criminal hold order and as long as the person continues to meet other eligibility requirements of this subdivision.

(g) General assistance medical care is not available for applicants or recipients who do not cooperate with the county agency to meet the requirements of medical assistance.

(h) In determining the amount of assets of an individual eligible under paragraph (a), clause (2), item (i), there shall be included any asset or interest in an asset, including an asset excluded under paragraph (a), that was given away, sold, or disposed of for less than fair market value within the 60 months preceding application for general assistance medical care or during the period of eligibility. Any transfer described in this paragraph shall be presumed to have been for the purpose of establishing eligibility for general assistance medical care, unless the individual furnishes convincing evidence to establish that the transaction was exclusively for another purpose. For purposes of this paragraph, the value of the asset or interest shall be the fair market value at the time it was given away, sold, or disposed of, less the amount of compensation received. For any uncompensated transfer, the number of months of ineligibility, including partial months, shall be calculated by dividing the uncompensated transfer amount by the average monthly per person payment made by the medical assistance

program to skilled nursing facilities for the previous calendar year. The individual shall remain ineligible until this fixed period has expired. The period of ineligibility may exceed 30 months, and a reapplication for benefits after 30 months from the date of the transfer shall not result in eligibility unless and until the period of ineligibility has expired. The period of ineligibility begins in the month the transfer was reported to the county agency, or if the transfer was not reported, the month in which the county agency discovered the transfer, whichever comes first. For applicants, the period of ineligibility begins on the date of the first approved application.

(i) When determining eligibility for any state benefits under this subdivision, the income and resources of all noncitizens shall be deemed to include their sponsor's income and resources as defined in the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, title IV, Public Law 104-193, sections 421 and 422, and subsequently set out in federal rules.

(j) Undocumented noncitizens and nonimmigrants are ineligible for general assistance medical care. For purposes of this subdivision, a nonimmigrant is an individual in one or more of the classes listed in United States Code, title 8, section 1101(a)(15), and an undocumented noncitizen is an individual who resides in the United States without the approval or acquiescence of the Immigration and Naturalization Service.

(k) Notwithstanding any other provision of law, a noncitizen who is ineligible for medical assistance due to the deeming of a sponsor's income and resources, is ineligible for general assistance medical care.

(l) Effective July 1, 2003, general assistance medical care emergency services end.

Sec. 37. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3,

paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this

paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards

and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

(g) The co-payments described in paragraph (d) shall be waived by the provider if the recipient practices a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general

assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 38. Minnesota Statutes 2004, section 256L.03, subdivision 1, is amended to read:

Subdivision 1. [COVERED HEALTH SERVICES.] ~~For individuals under section 256L.04, subdivision 7, with income no greater than 75 percent of the federal poverty guidelines or for families with children under section 256L.04, subdivision 1, all subdivisions of this section apply.~~ "Covered health services" means the health services reimbursed under chapter 256B, with the exception of inpatient hospital services, special education services, private duty nursing services, adult dental care services other than preventive services ~~covered under section 256B.0625, subdivision 9, paragraph (b)~~, orthodontic services, nonemergency medical transportation services, personal care assistant and case management services, nursing home or intermediate care facilities services, inpatient mental health

services, and chemical dependency services. Adult dental care for nonpreventive services, with the exception of orthodontic services, is covered for persons who qualify under section 256L.04, subdivisions 1, 2, and 7, with family gross income equal to or less than 175 percent of the federal poverty guidelines. Outpatient mental health services covered under the MinnesotaCare program are limited to diagnostic assessments, psychological testing, explanation of findings, medication management by a physician, day treatment, partial hospitalization, and individual, family, and group psychotherapy.

No public funds shall be used for coverage of abortion under MinnesotaCare except where the life of the female would be endangered or substantial and irreversible impairment of a major bodily function would result if the fetus were carried to term; or where the pregnancy is the result of rape or incest.

Covered health services shall be expanded as provided in this section.

Sec. 39. Minnesota Statutes 2004, section 256L.05, subdivision 4, is amended to read:

Subd. 4. [APPLICATION PROCESSING.] The commissioner of human services shall determine an applicant's eligibility for MinnesotaCare no more than 30 days from the date that the application is received by the Department of Human Services. Beginning January 1, 2000, this requirement also applies to local county human services agencies that determine eligibility for MinnesotaCare. At application or reenrollment, to prevent processing delays, applicants or enrollees who, from the information provided on the application, appear to meet eligibility requirements shall be enrolled upon timely payment of premiums. The enrollee must provide all required verifications within 30 days of notification of the eligibility determination or coverage from the program shall be terminated. Enrollees who are determined to be ineligible when verifications are provided shall be disenrolled from the program.

Sec. 40. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c)~~(1)~~ Notwithstanding paragraph (b), individuals and families ~~enrolled in MinnesotaCare under section 256L.04, subdivision 1,~~ may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given ~~an 18-month~~ a 12-month notice period

from the date that ineligibility is determined before disenrollment. ~~This clause expires February 1, 2004.~~

~~(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12 month notice period from the date that ineligibility is determined before disenrollment.~~ The premium for ~~children~~ individuals and families remaining eligible under this ~~clause~~ paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

Sec. 41. Minnesota Statutes 2004, section 256L.12, subdivision 6, is amended to read:

Subd. 6. [CO-PAYMENTS AND BENEFIT LIMITS.] Enrollees are responsible for all co-payments in ~~sections~~ section 256L.03, subdivision 5, ~~and 256L.035~~, and shall pay co-payments to the managed care plan or to its participating providers. The enrollee is also responsible for payment of inpatient hospital charges which exceed the MinnesotaCare benefit limit.

Sec. 42. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible

employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty

guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 43. Laws 2003, First Special Session chapter 14,

article 6, section 65, is amended to read:

Sec. 65. [FEDERAL GRANTS TO MAINTAIN INDEPENDENCE AND EMPLOYMENT.]

(a) The commissioner of human services shall seek federal funding to participate in grant activities authorized under Public Law 106-170, the Ticket to Work and Work Incentives Improvement Act of 1999. The purpose of the federal grant funds are to establish:

(1) a demonstration project to improve the availability of health care services and benefits to workers with potentially severe physical or mental impairments that are likely to lead to disability without access to Medicaid services; and

(2) a comprehensive initiative to remove employment barriers that includes linkages with non-Medicaid programs, including those administered by the Social Security Administration and the Department of Labor.

(b) The state's proposal for a demonstration project in paragraph (a), clause (1), shall focus on assisting workers with:

(1) a serious mental illness as defined by the federal Center for Mental Health Services;

(2) concurrent mental health and chemical dependency conditions; ~~and~~

(3) young adults up to the age of 24 who have a physical or mental impairment that is severe and will potentially lead to a determination of disability by the Social Security Administration or state medical review team; and

(4) adults without children who are eligible for MinnesotaCare and who suffer from one or more of the following chronic health conditions: diabetes, hypertension, coronary artery disease, asthma, thyroid disease, cancer, chronic arthritis, HIV, or multiple sclerosis.

(c) The commissioner is authorized to take the actions necessary to design and implement the demonstration project in paragraph (a), clause (1), that include:

(1) establishing work-related requirements for participation in the demonstration project;

(2) working with stakeholders to establish methods that identify the population that will be served in the demonstration project;

(3) seeking funding for activities to design, implement, and evaluate the demonstration project;

(4) taking necessary administrative actions to implement the demonstration project by July 1, 2004, or within 180 days of receiving formal notice from the Centers for Medicare and Medicaid Services that a grant has been awarded;

(5) establishing limits on income and resources;

(6) establishing a method to coordinate health care benefits and payments with other coverage that is available to the participants;

(7) establishing premiums based on guidelines that are consistent with those found in Minnesota Statutes, section 256B.057, subdivision 9, for employed persons with disabilities;

(8) notifying local agencies of potentially eligible individuals in accordance with Minnesota Statutes, section 256B.19, subdivision 2c; and

(9) limiting the caseload of qualifying individuals participating in the demonstration project.

(d) The state's proposal for the comprehensive employment initiative in paragraph (a), clause (2), shall focus on:

(1) infrastructure development that creates incentives for greater work effort and participation by people with disabilities or workers with severe physical or mental impairments;

(2) consumer access to information and benefit assistance that enables the person to maximize employment and career advancement potential;

(3) improved consumer access to essential assistance and support;

(4) enhanced linkages between state and federal agencies to decrease the barriers to employment experienced by persons with disabilities or workers with severe physical or mental impairments; and

(5) research efforts to provide useful information to guide future policy development on both the state and federal levels.

(e) Funds awarded by the federal government for the purposes of this section are appropriated to the commissioner of human services.

(f) The commissioner shall report to the chairs of the senate and house of representatives finance divisions having jurisdiction over health care issues on the federal approval of the waiver under this section and the projected savings in the November and February forecasts. Any savings projected for the individuals described in paragraph (b), clause (4), shall be deposited in the health care access fund.

The commissioner must consider using the savings to increase GAMC hospital rates to the July 1, ~~2003~~ 2004, levels as a ~~supplemental~~ budget proposal in the ~~2004~~ 2005 legislative session.

Sec. 44. [DISEASE MANAGEMENT PROGRAM ACCOUNTABILITY.]

Any savings generated from the disease management initiatives under Minnesota Statutes, section 256B.075, shall be retained by the commissioner of human services and used for provider bonuses in the disease management program as described in Minnesota Statutes, section 256B.075, and for increasing other provider rates within the fee-for-service program.

Sec. 45. [FEDERAL 340B DRUG PRICING PROGRAM INFORMATION.]

The commissioner of human services, in consultation with other state agencies and representatives of health care providers and facilities in the state, shall provide the following information:

(1) a description of all health care providers and facilities in the state potentially eligible for designation as a "covered entity" under section 340B of the federal Veterans Health Care Act of 1992, Public Law 102-585, including, but not limited to, all hospitals eligible as disproportionate share hospitals; recipients of grants from the United States Public Health Service; federally qualified health centers; state-operated AIDS drug assistance programs; Ryan White Care

Act, title I, title II, and title III programs; family planning and sexually transmitted disease clinics; hemophilia treatment centers; public housing primary care clinics; and clinics for homeless people. The commissioner may encourage those facilities that are or may be eligible to participate in the program and may provide any necessary technical assistance to access the program; and

(2) a list of potential applications of section 340B and the potential benefits to public, private, and third-party payers, including, but not limited to:

(i) evaluating methods to allow community mental health patients to obtain medications through 340B providers;

(ii) maximizing the use of 340B providers within state-funded managed care plans;

(iii) including 340B providers in state bulk purchasing initiatives; and

(iv) utilizing sole source contracts with 340B providers to furnish high-cost chronic care drugs.

Sec. 46. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [GENERAL ASSISTANCE MEDICAL CARE AND MINNESOTACARE.] (a) Effective July 1, 2005, the diagnosis/treatment pairings described in subdivision 3 shall not be covered under the general assistance medical care program or under the MinnesotaCare program for persons eligible under Minnesota Statutes, section 256L.04, subdivision 7.

(b) This subdivision expires July 1, 2007, or when a list is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [PRIOR AUTHORIZATION OF SERVICES FOR MEDICAL ASSISTANCE.] (a) Effective July 1, 2005, prior authorization is required for the diagnosis/treatment pairings described in subdivision 3 for reimbursement under Minnesota Statutes, chapter 256B, and under the MinnesotaCare program for persons eligible under Minnesota Statutes, section 256L.04, subdivision

1 1.
2 (b) This subdivision expires July 1, 2007, or when a list
3 is established according to Minnesota Statutes, section
4 256B.0625, subdivision 46, whichever is earlier.
5 Subd. 3. [LIST OF DIAGNOSIS/TREATMENT PAIRINGS.] (a)(1)
6 Diagnosis: TRIGEMINAL AND OTHER NERVE DISORDERS
7 Treatment: MEDICAL AND SURGICAL TREATMENT
8 ICD-9: 350,352
9 (2) Diagnosis: DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF
10 THE ARMS AND LEGS, EXCLUDING THE KNEE, GRADE II AND III
11 Treatment: REPAIR
12 ICD-9: 726.5, 727.59, 727.62-727.65, 727.68-727.69, 728.83,
13 728.89, 840.0-840.3, 840.5-840.9, 841-843, 845.0
14 (3) Diagnosis: DISORDERS OF SHOULDER
15 Treatment: REPAIR/RECONSTRUCTION
16 ICD-9: 718.01, 718.11, 718.21, 718.31, 718.41, 718.51, 718.81,
17 726.0, 726.10-726.11, 726.19, 726.2, 727.61, 840.4, 840.7
18 (4) Diagnosis: INTERNAL DERANGEMENT OF KNEE AND
19 LIGAMENTOUS DISRUPTIONS OF THE KNEE, GRADE II AND III
20 Treatment: REPAIR, MEDICAL THERAPY
21 ICD-9: 717.0-717.4, 717.6-717.8, 718.26, 718.36, 718.46,
22 718.56, 727.66, 836.0-836.2, 844
23 (5) Diagnosis: MALUNION AND NONUNION OF FRACTURE
24 Treatment: SURGICAL TREATMENT
25 ICD-9: 733.8
26 (6) Diagnosis: FOREIGN BODY IN UTERUS, VULVA AND VAGINA
27 Treatment: MEDICAL AND SURGICAL TREATMENT
28 ICD-9: 939.1-939.2
29 (7) Diagnosis: UTERINE PROLAPSE; CYSTOCELE
30 Treatment: SURGICAL REPAIR
31 ICD-9: 618
32 (8) Diagnosis: OSTEOARTHRITIS AND ALLIED DISORDERS
33 Treatment: MEDICAL THERAPY, INJECTIONS
34 ICD-9: 713.5, 715, 716.0-716.1, 716.5-716.6
35 (9) Diagnosis: METABOLIC BONE DISEASE
36 Treatment: MEDICAL THERAPY

ICD-9: 731.0, 733.0

(10) Diagnosis: SYMPTOMATIC IMPACTED TEETH

Treatment: SURGERY

ICD-9: 520.6, 524.3-524.4

(11) Diagnosis: UNSPECIFIED DISEASE OF HARD TISSUES OF TEETH (AVULSION)

Treatment: INTERDENTAL WIRING

ICD-9: 525.9

(12) Diagnosis: ABSCESSES AND CYSTS OF BARTHOLIN'S GLAND AND VULVA

Treatment: INCISION AND DRAINAGE, MEDICAL THERAPY

ICD-9: 616.2-616.9

(13) Diagnosis: CERVICITIS, ENDOCERVICITIS, HEMATOMA OF VULVA, AND NONINFLAMMATORY DISORDERS OF THE VAGINA

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 616.0, 623.6, 623.8-623.9, 624.5

(14) Diagnosis: DENTAL CONDITIONS (e.g., TOOTH LOSS)

Treatment: SPACE MAINTENANCE AND PERIODONTAL MAINTENANCE

ICD-9: V72.2

(15) Diagnosis: URINARY INCONTINENCE

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 599.81, 625.6, 788.31-788.33

(16) Diagnosis: HYPOSPADIAS AND EPISPADIAS

Treatment: REPAIR

ICD-9: 752.6

(17) Diagnosis: RESIDUAL FOREIGN BODY IN SOFT TISSUE

Treatment: REMOVAL

ICD-9: 374.86, 729.6, 883.1-883.2

(18) Diagnosis: BRANCHIAL CLEFT CYST

Treatment: EXCISION, MEDICAL THERAPY

ICD-9: 744.41-744.46, 744.49, 759.2

(19) Diagnosis: EXFOLIATION OF TEETH DUE TO SYSTEMIC CAUSES; SPECIFIC DISORDERS OF THE TEETH AND SUPPORTING STRUCTURES

Treatment: EXCISION OF DENTOALVEOLAR STRUCTURE

ICD-9: 525.0, 525.8, 525.11

(20) Diagnosis: PTOSIS (ACQUIRED) WITH VISION IMPAIRMENT
Treatment: PTOSIS REPAIR
ICD-9: 374.2-374.3, 374.41, 374.43, 374.46
(21) Diagnosis: SIMPLE AND SOCIAL PHOBIAS
Treatment: MEDICAL/PSYCHOTHERAPY
ICD-9: 300.23, 300.29
(22) Diagnosis: RETAINED DENTAL ROOT
Treatment: EXCISION OF DENTOALVEOLAR STRUCTURE
ICD-9: 525.3
(23) Diagnosis: PERIPHERAL NERVE ENTRAPMENT
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 354.0, 354.2, 355.5, 723.3, 728.6
(24) Diagnosis: INCONTINENCE OF FECES
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 787.6
(25) Diagnosis: RECTAL PROLAPSE
Treatment: PARTIAL COLECTOMY
ICD-9: 569.1-569.2
(26) Diagnosis: BENIGN NEOPLASM OF KIDNEY AND OTHER URINARY ORGANS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 223
(27) Diagnosis: URETHRAL FISTULA
Treatment: EXCISION, MEDICAL THERAPY
ICD-9: 599.1-599.2, 599.4
(28) Diagnosis: THROMBOSED AND COMPLICATED HEMORRHOIDS
Treatment: HEMORRHOIDECTOMY, INCISION
ICD-9: 455.1-455.2, 455.4-455.5, 455.7-455.8
(29) Diagnosis: VAGINITIS, TRICHOMONIASIS
Treatment: MEDICAL THERAPY
ICD-9: 112.1, 131, 616.1, 623.5
(30) Diagnosis: BALANOPOSTHITIS AND OTHER DISORDERS OF PENIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 607.1, 607.81-607.83, 607.89
(31) Diagnosis: CHRONIC ANAL FISSURE; ANAL FISTULA

Treatment: SPHINCTEROTOMY, FISSURECTOMY, FISTULECTOMY, MEDICAL THERAPY
ICD-9: 565.0-565.1

(32) Diagnosis: CHRONIC OTITIS MEDIA
Treatment: PE TUBES/ADENOIDECTOMY/TYMPANOPLASTY, MEDICAL THERAPY
ICD-9: 380.5, 381.1-381.8, 382.1-382.3, 382.9, 383.1-383.2, 383.30-383.31, 383.9, 384.2, 384.8-384.9

(33) Diagnosis: ACUTE CONJUNCTIVITIS
Treatment: MEDICAL THERAPY
ICD-9: 077, 372.00

(34) Diagnosis: CERUMEN IMPACTION, FOREIGN BODY IN EAR & NOSE
Treatment: REMOVAL OF FOREIGN BODY
ICD-9: 380.4, 931-932

(35) Diagnosis: VERTIGINOUS SYNDROMES AND OTHER DISORDERS OF VESTIBULAR SYSTEM
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 379.54, 386.1-386.2, 386.4-386.9, 438.6-438.7, 438.83-438.85

(36) Diagnosis: UNSPECIFIED URINARY OBSTRUCTION AND BENIGN PROSTATIC HYPERPLASIA WITHOUT OBSTRUCTION
Treatment: MEDICAL THERAPY
ICD-9: 599.6, 600

(37) Diagnosis: PHIMOSIS
Treatment: SURGICAL TREATMENT
ICD-9: 605

(38) Diagnosis: CONTACT DERMATITIS, ATOPIC DERMATITIS AND OTHER ECZEMA
Treatment: MEDICAL THERAPY
ICD-9: 691.8, 692.0-692.6, 692.70-692.74, 692.79, 692.8-692.9

(39) Diagnosis: PSORIASIS AND SIMILAR DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 696.1-696.2, 696.8

(40) Diagnosis: CYSTIC ACNE
Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 705.83, 706.0-706.1

(41) Diagnosis: CLOSED FRACTURE OF GREAT TOE

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 826.0

(42) Diagnosis: SYMPTOMATIC URTICARIA

Treatment: MEDICAL THERAPY

ICD-9: 708.0-708.1, 708.5, 708.8, 995.7

(43) Diagnosis: PERIPHERAL NERVE DISORDERS

Treatment: SURGICAL TREATMENT

ICD-9: 337.2, 353, 354.1, 354.3-354.9, 355.0, 355.3, 355.4, 355.7-355.8, 723.2

(44) Diagnosis: DYSFUNCTION OF NASOLACRIMAL SYSTEM; LACRIMAL SYSTEM LACERATION

Treatment: MEDICAL AND SURGICAL TREATMENT; CLOSURE

ICD-9: 370.33, 375, 870.2

(45) Diagnosis: NASAL POLYPS, OTHER DISORDERS OF NASAL CAVITY AND SINUSES

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 471, 478.1, 993.1

(46) Diagnosis: SIALOLITHIASIS, MUCOCELE, DISTURBANCE OF SALIVARY SECRETION, OTHER AND UNSPECIFIED DISEASES OF SALIVARY GLANDS

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 527.5-527.9

(47) Diagnosis: DENTAL CONDITIONS (e.g., BROKEN APPLIANCES)

Treatment: PERIODONTICS AND COMPLEX PROSTHETICS

ICD-9: 522.6, 522.8, V72.2

(48) Diagnosis: IMPULSE DISORDERS

Treatment: MEDICAL/PSYCHOTHERAPY

ICD-9: 312.31-312.39

(49) Diagnosis: BENIGN NEOPLASM BONE AND ARTICULAR CARTILAGE, INCLUDING OSTEOID OSTEOMAS; BENIGN NEOPLASM OF CONNECTIVE AND OTHER SOFT TISSUE

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 213, 215, 526.0-526.1, 526.81, 719.2, 733.2

(50) Diagnosis: SEXUAL DYSFUNCTION

Treatment: MEDICAL AND SURGICAL TREATMENT, PSYCHOTHERAPY
ICD-9: 302.7, 607.84
(51) Diagnosis: STOMATITIS AND DISEASES OF LIPS
Treatment: INCISION AND DRAINAGE/MEDICAL THERAPY
ICD-9: 528.0, 528.5, 528.9, 529.0
(52) Diagnosis: BELL'S PALSY, EXPOSURE KERATOCONJUNCTIVITIS
Treatment: TARSORRHAPHY
ICD-9: 351.0-351.1, 351.8-351.9, 370.34, 374.44, 374.45, 374.89
(53) Diagnosis: HORDEOLUM AND OTHER DEEP INFLAMMATION OF EYELID; CHALAZION
Treatment: INCISION AND DRAINAGE/MEDICAL THERAPY
ICD-9: 373.11-373.12, 373.2, 374.50, 374.54, 374.56, 374.84
(54) Diagnosis: ECTROPION, TRICHIASIS OF EYELID, BENIGN NEOPLASM OF EYELID
Treatment: ECTROPION REPAIR
ICD-9: 216.1, 224, 372.63, 374.1, 374.85
(55) Diagnosis: CHONDROMALACIA
Treatment: MEDICAL THERAPY
ICD-9: 733.92
(56) Diagnosis: DYSMENORRHEA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 625.3
(57) Diagnosis: SPASTIC DIPLEGIA
Treatment: RHIZOTOMY
ICD-9: 343.0
(58) Diagnosis: ATROPHY OF EDENTULOUS ALVEOLAR RIDGE
Treatment: VESTIBULOPLASTY, GRAFTS, IMPLANTS
ICD-9: 525.2
(59) Diagnosis: DEFORMITIES OF UPPER BODY AND ALL LIMBS
Treatment: REPAIR/REVISION/RECONSTRUCTION/RELOCATION/MEDICAL THERAPY
ICD-9: 718.02-718.05, 718.13-718.15, 718.42-718.46, 718.52-718.56, 718.65, 718.82-718.86, 728.79, 732.3, 732.6, 732.8-732.9, 733.90-733.91, 736.00-736.04, 736.07, 736.09, 736.1, 736.20, 736.29, 736.30, 736.39, 736.4, 736.6, 736.76,

736.79, 736.89, 736.9, 738.6, 738.8, 754.42-754.44, 754.61, 754.8, 755.50-755.53, 755.56-755.57, 755.59, 755.60, 755.63-755.64, 755.69, 755.8, 756.82-756.83, 756.89

(60) Diagnosis: DEFORMITIES OF FOOT
Treatment: FASCIOTOMY/INCISION/REPAIR/ARTHRODESIS
ICD-9: 718.07, 718.47, 718.57, 718.87, 727.1, 732.5, 735.0-735.2, 735.3-735.9, 736.70-736.72, 754.50, 754.59, 754.60, 754.69, 754.70, 754.79, 755.65-755.67

(61) Diagnosis: PERITONEAL ADHESION
Treatment: SURGICAL TREATMENT
ICD-9: 568.0, 568.82-568.89, 568.9

(62) Diagnosis: PELVIC PAIN SYNDROME, DYSPAREUNIA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 300.81, 614.1, 614.6, 620.6, 625.0-625.2, 625.5, 625.8-625.9

(63) Diagnosis: TENSION HEADACHES
Treatment: MEDICAL THERAPY
ICD-9: 307.81, 784.0

(64) Diagnosis: CHRONIC BRONCHITIS
Treatment: MEDICAL THERAPY
ICD-9: 490, 491.0, 491.8-491.9

(65) Diagnosis: DISORDERS OF FUNCTION OF STOMACH AND OTHER FUNCTIONAL DIGESTIVE DISORDERS
Treatment: MEDICAL THERAPY
ICD-9: 536.0-536.3, 536.8-536.9, 537.1-537.2, 537.5-537.6, 537.89, 537.9, 564.0-564.7, 564.9

(66) Diagnosis: TMJ DISORDER
Treatment: TMJ SPLINTS
ICD-9: 524.6, 848.1

(67) Diagnosis: URETHRITIS, NONSEXUALLY TRANSMITTED
Treatment: MEDICAL THERAPY
ICD-9: 597.8, 599.3-599.5, 599.9

(68) Diagnosis: LESION OF PLANTAR NERVE; PLANTAR FASCIAL FIBROMATOSIS
Treatment: MEDICAL THERAPY, EXCISION
ICD-9: 355.6, 728.71

(69) Diagnosis: GRANULOMA OF MUSCLE, GRANULOMA OF SKIN AND SUBCUTANEOUS TISSUE
Treatment: REMOVAL OF GRANULOMA
ICD-9: 709.4, 728.82
(70) Diagnosis: DERMATOPHYTOSIS OF NAIL, GROIN, AND FOOT AND OTHER DERMATOMYCOSIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 110.0-110.6, 110.8-110.9, 111
(71) Diagnosis: INTERNAL DERANGEMENT OF JOINT OTHER THAN KNEE
Treatment: REPAIR, MEDICAL THERAPY
ICD-9: 718.09, 718.19, 718.29, 718.48, 718.59, 718.88-718.89, 719.81-719.85, 719.87-719.89
(72) Diagnosis: STENOSIS OF NASOLACRIMAL DUCT (ACQUIRED)
Treatment: DACRYOCYSTORHINOSTOMY
ICD-9: 375.02, 375.30, 375.32, 375.4, 375.56-375.57, 375.61, 771.6
(73) Diagnosis: PERIPHERAL NERVE DISORDERS
Treatment: SURGICAL TREATMENT
ICD-9: 337.2, 353, 354.1, 354.3-354.9, 355.0, 355.3, 355.4, 355.7-355.8, 723.2
(74) Diagnosis: CAVUS DEFORMITY OF FOOT; FLAT FOOT; POLYDACTYLY AND SYNDACTYLY OF TOES
Treatment: MEDICAL THERAPY, ORTHOTIC
ICD-9: 734, 736.73, 755.00, 755.02, 755.10, 755.13-755.14
(75) Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: SURGICAL TREATMENT
ICD-9: 726.12, 726.3-726.9, 728.81
(76) Diagnosis: PERIPHERAL ENTHESOPATHIES
Treatment: MEDICAL THERAPY
ICD-9: 726.12, 726.3-726.4, 726.6-726.9, 728.81
(77) Diagnosis: DISORDERS OF SOFT TISSUE
Treatment: MEDICAL THERAPY
ICD-9: 729.0-729.2, 729.31-729.39, 729.4-729.9
(78) Diagnosis: ENOPHTHALMOS
Treatment: ORBITAL IMPLANT

ICD-9: 372.64, 376.5

(79) Diagnosis: MACROMASTIA

Treatment: SUBCUTANEOUS TOTAL MASTECTOMY, BREAST REDUCTION

ICD-9: 611.1

(80) Diagnosis: GALACTORRHEA, MASTODYNIA, ATROPHY, BENIGN NEOPLASMS AND UNSPECIFIED DISORDERS OF THE BREAST

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 217, 611.3, 611.4, 611.6, 611.71, 611.9, 757.6

(81) Diagnosis: ACUTE AND CHRONIC DISORDERS OF SPINE WITHOUT NEUROLOGIC IMPAIRMENT

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 721.0, 721.2-721.3, 721.7-721.8, 721.90, 722.0-722.6, 722.8-722.9, 723.1, 723.5-723.9, 724.1-724.2, 724.5-724.9, 739, 839.2, 847

(82) Diagnosis: CYSTS OF ORAL SOFT TISSUES

Treatment: INCISION AND DRAINAGE

ICD-9: 527.1, 528.4, 528.8

(83) Diagnosis: FEMALE INFERTILITY, MALE INFERTILITY

Treatment: ARTIFICIAL INSEMINATION, MEDICAL THERAPY

ICD-9: 606, 628.4-628.9, 629.9, V26.1-V26.2, V26.8-V26.9

(84) Diagnosis: INFERTILITY DUE TO ANNOVULATION

Treatment: MEDICAL THERAPY

ICD-9: 626.0-626.1, 628.0, 628.1

(85) Diagnosis: POSTCONCUSSION SYNDROME

Treatment: MEDICAL THERAPY

ICD-9: 310.2

(86) Diagnosis: SIMPLE AND UNSPECIFIED GOITER, NONTOXIC NODULAR GOITER

Treatment: MEDICAL THERAPY, THYROIDECTOMY

ICD-9: 240-241

(87) Diagnosis: CONDUCTIVE HEARING LOSS

Treatment: AUDIANT BONE CONDUCTORS

ICD-9: 389.0, 389.2

(88) Diagnosis: CANCER OF LIVER AND INTRAHEPATIC BILE DUCTS

Treatment: LIVER TRANSPLANT

ICD-9: 155.0-155.1, 996.82

(89) Diagnosis: HYPOTENSION

Treatment: MEDICAL THERAPY

ICD-9: 458

(90) Diagnosis: VIRAL HEPATITIS, EXCLUDING CHRONIC VIRAL HEPATITIS B AND VIRAL HEPATITIS C WITHOUT HEPATIC COMA

Treatment: MEDICAL THERAPY

ICD-9: 070.0-070.2, 070.30-070.31, 070.33, 070.4, 070.52-070.53, 070.59, 070.6-070.9

(91) Diagnosis: BENIGN NEOPLASMS OF SKIN AND OTHER SOFT TISSUES

Treatment: MEDICAL THERAPY

ICD-9: 210, 214, 216, 221, 222.1, 222.4, 228.00-228.01, 228.1, 229, 686.1, 686.9

(92) Diagnosis: REDUNDANT PREPUCE

Treatment: ELECTIVE CIRCUMCISION

ICD-9: 605, V50.2

(93) Diagnosis: BENIGN NEOPLASMS OF DIGESTIVE SYSTEM

Treatment: SURGICAL TREATMENT

ICD-9: 211.0-211.2, 211.5-211.6, 211.8-211.9

(94) Diagnosis: OTHER NONINFECTIOUS GASTROENTERITIS AND COLITIS

Treatment: MEDICAL THERAPY

ICD-9: 558

(95) Diagnosis: FACTITIOUS DISORDERS

Treatment: CONSULTATION

ICD-9: 300.10, 300.16, 300.19, 301.51

(96) Diagnosis: HYPOCHONDRIASIS; SOMATOFORM DISORDER, NOS AND UNDIFFERENTIATED

Treatment: CONSULTATION

ICD-9: 300.7, 300.9, 306

(97) Diagnosis: CONVERSION DISORDER, ADULT

Treatment: MEDICAL/PSYCHOTHERAPY

ICD-9: 300.11

(98) Diagnosis: SPINAL DEFORMITY, NOT CLINICALLY SIGNIFICANT

Treatment: ARTHRODESIS/REPAIR/RECONSTRUCTION, MEDICAL THERAPY
ICD-9: 721.5-721.6, 723.0, 724.0, 731.0, 737.0-737.3, 737.8-737.9, 738.4-738.5, 754.1-754.2, 756.10-756.12, 756.13-756.17, 756.19, 756.3

(99) Diagnosis: ASYMPTOMATIC URTICARIA
Treatment: MEDICAL THERAPY
ICD-9: 708.2-708.4, 708.9

(100) Diagnosis: CIRCUMSCRIBED SCLERODERMA; SENILE PURPURA
Treatment: MEDICAL THERAPY
ICD-9: 287.2, 287.8-287.9, 701.0

(101) Diagnosis: DERMATITIS DUE TO SUBSTANCES TAKEN INTERNALLY
Treatment: MEDICAL THERAPY
ICD-9: 693

(102) Diagnosis: ALLERGIC RHINITIS AND CONJUNCTIVITIS, CHRONIC RHINITIS
Treatment: MEDICAL THERAPY
ICD-9: 372.01-372.05, 372.14, 372.54, 372.56, 472, 477, 955.3, V07.1

(103) Diagnosis: PLEURISY
Treatment: MEDICAL THERAPY
ICD-9: 511.0, 511.9

(104) Diagnosis: CONJUNCTIVAL CYST
Treatment: EXCISION OF CONJUNCTIVAL CYST
ICD-9: 372.61-372.62, 372.71-372.72, 372.74-372.75

(105) Diagnosis: HEMATOMA OF AURICLE OR PINNA AND HEMATOMA OF EXTERNAL EAR
Treatment: DRAINAGE
ICD-9: 380.3, 380.8, 738.7

(106) Diagnosis: ACUTE NONSUPPURATIVE LABYRINTHITIS
Treatment: MEDICAL THERAPY
ICD-9: 386.30-386.32, 386.34-386.35

(107) Diagnosis: INFECTIOUS MONONUCLEOSIS
Treatment: MEDICAL THERAPY
ICD-9: 075

(108) Diagnosis: ASEPTIC MENINGITIS

Treatment: MEDICAL THERAPY

ICD-9: 047-049

(109) Diagnosis: CONGENITAL ANOMALIES OF FEMALE GENITAL ORGANS, EXCLUDING VAGINA

Treatment: SURGICAL TREATMENT

ICD-9: 752.0-752.3, 752.41

(110) Diagnosis: CONGENITAL DEFORMITIES OF KNEE

Treatment: ARTHROSCOPIC REPAIR

ICD-9: 755.64, 727.83

(111) Diagnosis: UNCOMPLICATED HERNIA IN ADULTS AGE 18 OR OVER

Treatment: REPAIR

ICD-9: 550.9, 553.0-553.2, 553.8-553.9

(112) Diagnosis: ACUTE ANAL FISSURE

Treatment: FISSURECTOMY, MEDICAL THERAPY

ICD-9: 565.0

(113) Diagnosis: CYST OF KIDNEY, ACQUIRED

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 593.2

(114) Diagnosis: PICA

Treatment: MEDICAL/PSYCHOTHERAPY

ICD-9: 307.52

(115) Diagnosis: DISORDERS OF SLEEP WITHOUT SLEEP APNEA

Treatment: MEDICAL THERAPY

ICD-9: 307.41-307.45, 307.47-307.49, 780.50, 780.52, 780.54-780.56, 780.59

(116) Diagnosis: CYST, HEMORRHAGE, AND INFARCTION OF THYROID

Treatment: SURGERY - EXCISION

ICD-9: 246.2, 246.3, 246.9

(117) Diagnosis: DEVIATED NASAL SEPTUM, ACQUIRED DEFORMITY OF NOSE, OTHER DISEASES OF UPPER RESPIRATORY TRACT

Treatment: EXCISION OF CYST/RHINECTOMY/PROSTHESIS

ICD-9: 470, 478.0, 738.0, 754.0

(118) Diagnosis: ERYTHEMA MULTIFORM

Treatment: MEDICAL THERAPY

ICD-9: 695.1

(119) Diagnosis: HERPES SIMPLEX WITHOUT COMPLICATIONS

Treatment: MEDICAL THERAPY

ICD-9: 054.2, 054.6, 054.73, 054.9

(120) Diagnosis: CONGENITAL ANOMALIES OF THE EAR WITHOUT IMPAIRMENT OF HEARING; UNILATERAL ANOMALIES OF THE EAR

Treatment: OTOPLASTY, REPAIR AND AMPUTATION

ICD-9: 744.00-744.04, 744.09, 744.1-744.3

(121) Diagnosis: BLEPHARITIS

Treatment: MEDICAL THERAPY

ICD-9: 373.0, 373.8-373.9, 374.87

(122) Diagnosis: HYPERTELORISM OF ORBIT

Treatment: ORBITOTOMY

ICD-9: 376.41

(123) Diagnosis: INFERTILITY DUE TO TUBAL DISEASE

Treatment: MICROSURGERY

ICD-9: 608.85, 622.5, 628.2-628.3, 629.9, V26.0

(124) Diagnosis: KERATODERMA, ACANTHOSIS NIGRICANS, STRIAE ATROPHICAE, AND OTHER HYPERTROPHIC OR ATROPHIC CONDITIONS OF SKIN

Treatment: MEDICAL THERAPY

ICD-9: 373.3, 690, 698, 701.1-701.3, 701.8, 701.9

(125) Diagnosis: LICHEN PLANUS

Treatment: MEDICAL THERAPY

ICD-9: 697

(126) Diagnosis: OBESITY

Treatment: NUTRITIONAL AND LIFESTYLE COUNSELING

ICD-9: 278.0

(127) Diagnosis: MORBID OBESITY

Treatment: GASTROPLASTY

ICD-9: 278.01

(128) Diagnosis: CHRONIC DISEASE OF TONSILS AND ADENOIDS

Treatment: TONSILLECTOMY AND ADENOIDECTOMY

ICD-9: 474.0, 474.1-474.2, 474.9

(129) Diagnosis: HYDROCELE

Treatment: MEDICAL THERAPY, EXCISION

ICD-9: 603, 608.84, 629.1, 778.6

(130) Diagnosis: KELOID SCAR; OTHER ABNORMAL GRANULATION TISSUE

Treatment: INTRALESIONAL INJECTIONS/DESTRUCTION/EXCISION, RADIATION THERAPY

ICD-9: 701.4-701.5

(131) Diagnosis: NONINFLAMMATORY DISORDERS OF CERVIX; HYPERTROPHY OF LABIA

Treatment: MEDICAL THERAPY

ICD-9: 622.4, 622.6-622.9, 623.4, 624.2-624.3, 624.6-624.9

(132) Diagnosis: SPRAINS OF JOINTS AND ADJACENT MUSCLES, GRADE I

Treatment: MEDICAL THERAPY

ICD-9: 355.1-355.3, 355.9, 717, 718.26, 718.36, 718.46, 718.56, 836.0-836.2, 840-843, 844.0-844.3, 844.8-844.9, 845.00-845.03, 845.1, 846, 848.3, 848.40-848.42, 848.49, 848.5, 848.8-848.9, 905.7

(133) Diagnosis: SYNOVITIS AND TENOSYNOVITIS

Treatment: MEDICAL THERAPY

ICD-9: 726.12, 727.00, 727.03-727.09

(134) Diagnosis: OTHER DISORDERS OF SYNOVIUM, TENDON AND BURSA, COSTOCHONDRITIS, AND CHONDRODYSTROPHY

Treatment: MEDICAL THERAPY

ICD-9: 719.5-719.6, 719.80, 719.86, 727.2-727.3, 727.50, 727.60, 727.82, 727.9, 733.5-733.7, 756.4

(135) Diagnosis: DISEASE OF NAILS, HAIR, AND HAIR FOLLICLES

Treatment: MEDICAL THERAPY

ICD-9: 703.8-703.9, 704.0, 704.1-704.9, 706.3, 706.9, 757.4-757.5, V50.0

(136) Diagnosis: CANDIDIASIS OF MOUTH, SKIN, AND NAILS

Treatment: MEDICAL THERAPY

ICD-9: 112.0, 112.3, 112.9

(137) Diagnosis: BENIGN LESIONS OF TONGUE

Treatment: EXCISION

ICD-9: 529.1-529.6, 529.8-529.9

(138) Diagnosis: MINOR BURNS
Treatment: MEDICAL THERAPY
ICD-9: 692.76, 941.0-941.2, 942.0-942.2, 943.0-943.2, 944.0-944.2, 945.0-945.2, 946.0-946.2, 949.0-949.1

(139) Diagnosis: MINOR HEAD INJURY: HEMATOMA/EDEMA WITH NO LOSS OF CONSCIOUSNESS
Treatment: MEDICAL THERAPY
ICD-9: 800.00-800.01, 801.00-801.01, 803.00-803.01, 850.0, 850.9, 851.00-851.01, 851.09, 851.20-851.21, 851.29, 851.40-851.41, 851.49, 851.60-851.61, 851.69, 851.80-851.81, 851.89

(140) Diagnosis: CONGENITAL DEFORMITY OF KNEE
Treatment: MEDICAL THERAPY
ICD-9: 755.64

(141) Diagnosis: PHLEBITIS AND THROMBOPHLEBITIS, SUPERFICIAL
Treatment: MEDICAL THERAPY
ICD-9: 451.0, 451.2, 451.82, 451.84, 451.89, 451.9

(142) Diagnosis: PROLAPSED URETHRAL MUCOSA
Treatment: SURGICAL TREATMENT
ICD-9: 599.3, 599.5

(143) Diagnosis: RUPTURE OF SYNOVIUM
Treatment: REMOVAL OF BAKER'S CYST
ICD-9: 727.51

(144) Diagnosis: PERSONALITY DISORDERS, EXCLUDING BORDERLINE, SCHIZOTYPAL AND ANTISOCIAL
Treatment: MEDICAL/PSYCHOTHERAPY
ICD-9: 301.0, 301.10-301.12, 301.20-301.21, 301.3-301.4, 301.50, 301.59, 301.6, 301.81-301.82, 301.84, 301.89, 301.9

(145) Diagnosis: GENDER IDENTIFICATION DISORDER, PARAPHILIAS AND OTHER PSYCHOSEXUAL DISORDERS
Treatment: MEDICAL/PSYCHOTHERAPY
ICD-9: 302.0-302.4, 302.50, 302.6, 302.85, 302.9

(146) Diagnosis: FINGERTIP AVULSION
Treatment: REPAIR WITHOUT PEDICLE GRAFT
ICD-9: 883.0

(147) Diagnosis: ANOMALIES OF RELATIONSHIP OF JAW TO CRANIAL BASE, MAJOR ANOMALIES OF JAW SIZE, OTHER SPECIFIED AND UNSPECIFIED DENTOFACIAL ANOMALIES
Treatment: OSTEOPLASTY, MAXILLA/MANDIBLE
ICD-9: 524.0-524.2, 524.5, 524.7-524.8, 524.9

(148) Diagnosis: CERVICAL RIB
Treatment: SURGICAL TREATMENT
ICD-9: 756.2

(149) Diagnosis: GYNECOMASTIA
Treatment: MASTECTOMY
ICD-9: 611.1

(150) Diagnosis: VIRAL, SELF-LIMITING ENCEPHALITIS, MYELITIS AND ENCEPHALOMYELITIS
Treatment: MEDICAL THERAPY
ICD-9: 056.0, 056.71, 323.8-323.9

(151) Diagnosis: GALLSTONES WITHOUT CHOLECYSTITIS
Treatment: MEDICAL THERAPY, CHOLECYSTECTOMY
ICD-9: 574.2, 575.8

(152) Diagnosis: BENIGN NEOPLASM OF NASAL CAVITIES, MIDDLE EAR AND ACCESSORY SINUSES
Treatment: EXCISION, RECONSTRUCTION
ICD-9: 212.0

(153) Diagnosis: ACUTE TONSILLITIS OTHER THAN BETA-STREPTOCOCCAL
Treatment: MEDICAL THERAPY
ICD-9: 463

(154) Diagnosis: EDEMA AND OTHER CONDITIONS INVOLVING THE INTEGUMENT OF THE FETUS AND NEWBORN
Treatment: MEDICAL THERAPY
ICD-9: 778.5, 778.7-778.9

(155) Diagnosis: ACUTE UPPER RESPIRATORY INFECTIONS AND COMMON COLD
Treatment: MEDICAL THERAPY
ICD-9: 460, 465

(156) Diagnosis: DIAPER RASH
Treatment: MEDICAL THERAPY

ICD-9: 691.0

(157) Diagnosis: DISORDERS OF SWEAT GLANDS

Treatment: MEDICAL THERAPY

ICD-9: 705.0-705.1, 705.81-705.83, 705.89, 705.9, 780.8

(158) Diagnosis: OTHER VIRAL INFECTIONS, EXCLUDING PNEUMONIA DUE TO RESPIRATORY SYNCYTIAL VIRUS IN PERSONS UNDER AGE 3

Treatment: MEDICAL THERAPY

ICD-9: 052, 055, 056.79, 056.8-056.9, 057, 072, 074, 078.0, 078.2, 078.4-078.8, 079.0-079.6, 079.88-079.89, 079.9, 480, 487

(159) Diagnosis: PHARYNGITIS AND LARYNGITIS AND OTHER DISEASES OF VOCAL CORDS

Treatment: MEDICAL THERAPY

ICD-9: 462, 464.00, 464.50, 476, 478.5

(160) Diagnosis: CORNS AND CALLUSES

Treatment: MEDICAL THERAPY

ICD-9: 700

(161) Diagnosis: VIRAL WARTS, EXCLUDING VENEREAL WARTS

Treatment: MEDICAL AND SURGICAL TREATMENT, CRYOSURGERY

ICD-9: 078.0, 078.10, 078.19

(162) Diagnosis: OLD LACERATION OF CERVIX AND VAGINA

Treatment: MEDICAL THERAPY

ICD-9: 621.5, 622.3, 624.4

(163) Diagnosis: TONGUE TIE AND OTHER ANOMALIES OF TONGUE

Treatment: FRENOTOMY, TONGUE TIE

ICD-9: 529.5, 750.0-750.1

(164) Diagnosis: OPEN WOUND OF INTERNAL STRUCTURES OF MOUTH WITHOUT COMPLICATION

Treatment: REPAIR SOFT TISSUES

ICD-9: 525.10, 525.12, 525.13, 525.19, 873.6

(165) Diagnosis: CENTRAL SEROUS RETINOPATHY

Treatment: LASER SURGERY

ICD-9: 362.40-362.41, 362.6-362.7

(166) Diagnosis: SEBORRHEIC KERATOSIS, DYSCHROMIA, AND VASCULAR DISORDERS, SCAR CONDITIONS, AND FIBROSIS OF SKIN

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 278.1, 702.1-702.8, 709.1-709.3, 709.8-709.9

(167) Diagnosis: UNCOMPLICATED HEMORRHOIDS

Treatment: HEMORRHOIDECTOMY, MEDICAL THERAPY

ICD-9: 455.0, 455.3, 455.6, 455.9

(168) Diagnosis: GANGLION

Treatment: EXCISION

ICD-9: 727.02, 727.4

(169) Diagnosis: CHRONIC CONJUNCTIVITIS, BLEPHAROCONJUNCTIVITIS

Treatment: MEDICAL THERAPY

ICD-9: 372.10-372.13, 372.2-372.3, 372.53, 372.73, 374.55

(170) Diagnosis: TOXIC ERYTHEMA, ACNE ROSACEA, DISCOID LUPUS

Treatment: MEDICAL THERAPY

ICD-9: 695.0, 695.2-695.9

(171) Diagnosis: PERIPHERAL NERVE DISORDERS

Treatment: MEDICAL THERAPY

ICD-9: 337.2, 353, 354.1, 354.3-354.9, 355.0, 355.3, 355.7-355.8, 357.5-357.9, 723.2

(172) Diagnosis: OTHER COMPLICATIONS OF A PROCEDURE

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 371.82, 457.0, 998.81, 998.9

(173) Diagnosis: RAYNAUD'S SYNDROME

Treatment: MEDICAL THERAPY

ICD-9: 443.0, 443.89, 443.9

(174) Diagnosis: TMJ DISORDERS

Treatment: TMJ SURGERY

ICD-9: 524.5, 524.6, 718.08, 718.18, 718.28, 718.38, 718.58

(175) Diagnosis: VARICOSE VEINS OF LOWER EXTREMITIES WITHOUT ULCER OR INFLAMMATION

Treatment: STRIPPING/SCLEROTHERAPY

ICD-9: 454.9, 459, 607.82

(176) Diagnosis: VULVAL VARICES

Treatment: VASCULAR SURGERY

ICD-9: 456.6

(177) Diagnosis: CHRONIC PANCREATITIS

Treatment: SURGICAL TREATMENT

ICD-9: 577.1

(178) Diagnosis: CHRONIC PROSTATITIS, OTHER DISORDERS OF PROSTATE

Treatment: MEDICAL THERAPY

ICD-9: 601.1, 601.3, 601.9, 602

(179) Diagnosis: MUSCULAR CALCIFICATION AND OSSIFICATION

Treatment: MEDICAL THERAPY

ICD-9: 728.1

(180) Diagnosis: CANCER OF VARIOUS SITES WHERE TREATMENT WILL NOT RESULT IN A FIVE PERCENT FIVE-YEAR SURVIVAL

Treatment: CURATIVE MEDICAL AND SURGICAL TREATMENT

ICD-9: 140-208

(181) Diagnosis: AGENESIS OF LUNG

Treatment: MEDICAL THERAPY

ICD-9: 748.5

(182) Diagnosis: DISEASE OF CAPILLARIES

Treatment: EXCISION

ICD-9: 448.1-448.9

(183) Diagnosis: BENIGN POLYPS OF VOCAL CORDS

Treatment: MEDICAL THERAPY, STRIPPING

ICD-9: 478.4

(184) Diagnosis: FRACTURES OF RIBS AND STERNUM, CLOSED

Treatment: MEDICAL THERAPY

ICD-9: 807.0, 807.2, 805.6, 839.41

(185) Diagnosis: CLOSED FRACTURE OF ONE OR MORE PHALANGES OF THE FOOT, NOT INCLUDING THE GREAT TOE

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 826.0

(186) Diagnosis: DISEASES OF THYMUS GLAND

Treatment: MEDICAL THERAPY

ICD-9: 254

(187) Diagnosis: DENTAL CONDITIONS WHERE TREATMENT RESULTS IN MARGINAL IMPROVEMENT

Treatment: ELECTIVE DENTAL SERVICES

ICD-9: 520.7, V72.2

(188) Diagnosis: ANTISOCIAL PERSONALITY DISORDER
Treatment: MEDICAL/PSYCHOTHERAPY
ICD-9: 301.7
(189) Diagnosis: SEBACEOUS CYST
Treatment: MEDICAL AND SURGICAL THERAPY
ICD-9: 685.1, 706.2, 744.47
(190) Diagnosis: CENTRAL RETINAL ARTERY OCCLUSION
Treatment: PARACENTESIS OF AQUEOUS
ICD-9: 362.31-362.33
(191) Diagnosis: ORAL APHTHAE
Treatment: MEDICAL THERAPY
ICD-9: 528.2
(192) Diagnosis: SUBLINGUAL, SCROTAL, AND PELVIC VARICES
Treatment: VENOUS INJECTION, VASCULAR SURGERY
ICD-9: 456.3-456.5
(193) Diagnosis: SUPERFICIAL WOUNDS WITHOUT INFECTION AND CONTUSIONS
Treatment: MEDICAL THERAPY
ICD-9: 910.0, 910.2, 910.4, 910.6, 910.8, 911.0, 911.2, 911.4, 911.6, 911.8, 912.0, 912.2, 912.4, 912.6, 912.8, 913.0, 913.2, 913.4, 913.6, 913.8, 914.0, 914.2, 914.4, 914.6, 914.8, 915.0, 915.2, 915.4, 915.6, 915.8, 916.0, 916.2, 916.4, 916.6, 916.8, 917.0, 917.2, 917.4, 917.6, 917.8, 919.0, 919.2, 919.4, 919.6, 919.8, 920-924, 959.0-959.8
(194) Diagnosis: UNSPECIFIED RETINAL VASCULAR OCCLUSION
Treatment: LASER SURGERY
ICD-9: 362.30
(195) Diagnosis: BENIGN NEOPLASM OF EXTERNAL FEMALE GENITAL ORGANS
Treatment: EXCISION
ICD-9: 221.1-221.9
(196) Diagnosis: BENIGN NEOPLASM OF MALE GENITAL ORGANS: TESTIS, PROSTATE, EPIDIDYMIS
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 222.0, 222.2, 222.3, 222.8, 222.9
(197) Diagnosis: XEROSIS

Treatment: MEDICAL THERAPY

ICD-9: 706.8

(198) Diagnosis: CONGENITAL CYSTIC LUNG - SEVERE

Treatment: LUNG RESECTION

ICD-9: 748.4

(199) Diagnosis: ICHTHYOSIS

Treatment: MEDICAL THERAPY

ICD-9: 757.1

(200) Diagnosis: LYMPHEDEMA

Treatment: MEDICAL THERAPY, OTHER OPERATION ON LYMPH CHANNEL

ICD-9: 457.1-457.9, 757.0

(201) Diagnosis: DERMATOLOGICAL CONDITIONS WITH NO EFFECTIVE TREATMENT OR NO TREATMENT NECESSARY

Treatment: MEDICAL AND SURGICAL TREATMENT

ICD-9: 696.3-696.5, 709.0, 757.2-757.3, 757.8-757.9

(202) Diagnosis: INFECTIOUS DISEASES WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 071, 136.0, 136.9

(203) Diagnosis: RESPIRATORY CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 519.3, 519.9, 748.60, 748.69, 748.9

(204) Diagnosis: GENITOURINARY CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 593.0-593.1, 593.6, 607.9, 608.3, 608.9, 621.6, 621.8-621.9, 626.9, 629.8, 752.9

(205) Diagnosis: CARDIOVASCULAR CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 429.3, 429.81-429.82, 429.89, 429.9, 747.9

(206) Diagnosis: MUSCULOSKELETAL CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 716.9, 718.00, 718.10, 718.20, 718.40, 718.50, 718.60,

718.80, 718.9, 719.7, 719.9, 728.5, 728.84, 728.9, 731.2, 738.2-738.3, 738.9, 744.5-744.9, 748.1, 755.9, 756.9

(207) Diagnosis: INTRACRANIAL CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 348.2, 377.01, 377.02, 377.2, 377.3, 377.5, 377.7, 437.7-437.8

(208) Diagnosis: SENSORY ORGAN CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 360.30-360.31, 360.33, 362.37, 362.42-362.43, 362.8-362.9, 363.21, 364.5, 364.60, 364.9, 371.20, 371.22, 371.24, 371.3, 371.81, 371.89, 371.9, 372.40-372.42, 372.44-372.45, 372.50-372.52, 372.55, 372.8-372.9, 374.52-374.53, 374.81-374.83, 374.9, 376.82, 376.89, 376.9, 377.03, 377.1, 377.4, 377.6, 379.24, 379.29, 379.4-379.8, 380.9, 747.47

(209) Diagnosis: ENDOCRINE AND METABOLIC CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 251.1-251.2, 259.4, 259.8-259.9, 277.3, 759.1

(210) Diagnosis: GASTROINTESTINAL CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 527.0, 569.9, 573.9

(211) Diagnosis: MENTAL DISORDERS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 313.1, 313.3, 313.83

(212) Diagnosis: NEUROLOGIC CONDITIONS WITH NO EFFECTIVE TREATMENTS OR NO TREATMENT NECESSARY

Treatment: EVALUATION

ICD-9: 333.82, 333.84, 333.91, 333.93

(213) Diagnosis: DENTAL CONDITIONS (e.g., ORTHODONTICS)

Treatment: COSMETIC DENTAL SERVICES

ICD-9: 520.0-520.5, 520.8-520.9, 521.1-521.9, 522.3, V72.2

(214) Diagnosis: TUBAL DYSFUNCTION AND OTHER CAUSES OF INFERTILITY
Treatment: IN-VITRO FERTILIZATION, GIFT
ICD-9: 256
(215) Diagnosis: HEPATORENAL SYNDROME
Treatment: MEDICAL THERAPY
ICD-9: 572.4
(216) Diagnosis: SPASTIC DYSPHONIA
Treatment: MEDICAL THERAPY
ICD-9: 478.79
(217) Diagnosis: DISORDERS OF REFRACTION AND ACCOMMODATION
Treatment: RADIAL KERATOTOMY
ICD-9: 367, 368.1-368.9

(b) The commissioner of human services shall identify the related CPT codes that correspond with the diagnosis/treatment pairings described in this section. The identification of the related CPT codes is not subject to the requirements of Minnesota Statutes, chapter 14, and Minnesota Statutes, section 14.386 does not apply.

Subd. 4. [FEDERAL APPROVAL.] The commissioner of human services shall seek federal approval to eliminate medical assistance coverage for the diagnosis/treatment pairings described in subdivision 3.

Subd. 5. [NONEXPANSION OF COVERED SERVICES.] Nothing in this section shall be construed to expand medical assistance coverage to services that are not currently covered under the medical assistance program as of June 30, 2005.

Sec. 47. [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

The commissioner of human services, in consultation with the Minnesota Hospital Association, Minnesota Medical Association, Minnesota Chamber of Commerce, and the Minnesota Business Partnership shall evaluate the effect of the limited hospital benefit under the MinnesotaCare program for single adults without children as it applies to the MinnesotaCare enrollment option for small employers described under Minnesota Statutes, section 256L.20. In the evaluation, the commissioner

shall determine whether this limitation discourages participation in the program by small employers, whether it has added to the amount of uncompensated care provided by hospitals, and the cost to the MinnesotaCare program if the hospital benefit limitation was eliminated for enrollees enrolled under Minnesota Statutes, section 256L.20. The commissioner shall submit the results of the evaluation to the legislature by January 15, 2006.

Sec. 48. [QUALITY IMPROVEMENT.]

The commissioners of human services and employee relations shall jointly develop a written plan for a provider payment system to be implemented by January 1, 2007. Under the provider payment system, a minimum of five percent of a provider's payment shall be withheld. Return of the withhold to a provider will be conditioned on the provider achieving certain quality improvement performance standards. The commissioners shall consult with local and national quality improvement groups to identify appropriate standards and measures related to performance. The plan must be submitted to the legislature by March 1, 2006. This provision does not prohibit the commissioners from negotiating the implementation of performance-based payment terms with particular providers prior to January 1, 2006.

Sec. 49. [TASK FORCE ON IMPROVING HEALTH STATUS OF STATE'S CHILDREN.]

(a) The commissioners of education, health, and human services shall convene a task force to study and make recommendations on the role of public schools in improving the health status of children. In order to assess the health status of children, the task force shall determine the number of children who are currently obese and set a goal, including measurable outcomes for the state in terms of reducing the rate of childhood obesity. The task force shall make recommendations on how to achieve this goal, including, but not limited to, increasing physical education activities within the public schools; exploring opportunities to promote physical education

and healthy eating programs; improving the nutritional offerings through breakfast and lunch menus; and evaluating the availability and choice of nutritional products offered in public schools. The members of the task force shall include representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public Health Association of Minnesota; the Minnesota Dietetic Association; the Minnesota School Food Service Association; the Minnesota Association of Health, Physical Education, Recreation, and Dance; the Minnesota School Boards Association; the Minnesota School Administrators Association; the Minnesota Secondary Principals Association; the vending industry; and consumers. The terms and compensation of the members of the task force shall be in accordance with Minnesota Statutes, section 15.059, subdivision 6.

(b) The commissioner must submit the recommendations of the task force to the legislature by January 15, 2006.

Sec. 50. [APPROPRIATION.]

(a) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;

(2) support practical nursing programs in regions of high need;

(3) address the shortage of nursing faculty; and

(4) provide accessible learning opportunities to students through distance education and simulation experiences.

(b) $..... is appropriated from the general fund to the commissioner of finance for transfer to the electronic medical record system loan fund to capitalize the fund. The appropriation is available until expended.

(c) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the commissioner of health for the loan forgiveness program in Minnesota Statutes,

section 144.1501.

(d) $500,000 is appropriated for fiscal year 2006 from the health care access fund to the Board of Regents of the University of Minnesota for the University of Minnesota's dental clinic to address dental care access for low-income patients.

Sec. 51. [REPEALER.]

Minnesota Statutes 2004, sections 256.955, subdivision 4a; 256B.075, subdivision 5; and 256L.035, are repealed.

APPENDIX
Repealed Minnesota Statutes for 05-0771

256.955 PRESCRIPTION DRUG PROGRAM.

Subd. 4a. **Referrals to prescription drug assistance program.** County social service agencies, in coordination with the commissioner and the Minnesota Board on Aging, shall refer individuals applying to the prescription drug program, or enrolled in the prescription drug program, to the prescription drug assistance program for all required prescription drugs that the Board on Aging determines, under section 256.975, subdivision 9, are covered under an assistance program offered by a pharmaceutical manufacturer. Applicants and enrollees referred to the prescription drug assistance program remain eligible for coverage under the prescription drug program of all prescription drugs covered under subdivision 3. The Board on Aging shall phase-in participation of enrollees, over a period of 90 days, after implementation of the program under section 256.975, subdivision 9. This subdivision does not apply to individuals who are also eligible for medical assistance with a spenddown as defined in section 256B.056, subdivision 5.

256B.075 DISEASE MANAGEMENT PROGRAMS.

Subd. 5. **Expiration.** This section expires June 30, 2006.

256L.035 LIMITED BENEFITS COVERAGE FOR CERTAIN SINGLE ADULTS AND HOUSEHOLDS WITHOUT CHILDREN.

(a) "Covered health services" for individuals under section 256L.04, subdivision 7, with income above 75 percent, but not exceeding 175 percent, of the federal poverty guideline means:

(1) inpatient hospitalization benefits with a ten percent co-payment up to $1,000 and subject to an annual limitation of $10,000;

(2) physician services provided during an inpatient stay; and

(3) physician services not provided during an inpatient stay, outpatient hospital services, freestanding ambulatory surgical center services, chiropractic services, lab and diagnostic services, and prescription drugs, subject to an aggregate cap of $2,000 per calendar year and the following co-payments:

(i) $50 co-pay per emergency room visit;

(ii) $3 co-pay per prescription drug; and

(iii) $5 co-pay per nonpreventive physician visit.

For purposes of this subdivision, "a visit" means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary.

Enrollees are responsible for all co-payments in this subdivision.

(b) The November 2006 MinnesotaCare forecast for the biennium beginning July 1, 2007, shall assume an adjustment in the aggregate cap on the services identified in paragraph (a), clause (3), in $1,000 increments up to a maximum of $10,000, but not less than $2,000, to the extent that the balance in the health care access fund is sufficient in each year of the biennium to pay for this benefit level. The aggregate cap shall be adjusted according to the forecast.

(c) Reimbursement to the providers shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug

co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (d).

(d) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient with uncollected debt before services can be denied.

Senator Berglin moves to amend S.F. No. 65 as follows:

Delete everything after the enacting clause and insert:

"Section 1. Minnesota Statutes 2004, section 62A.65, subdivision 3, is amended to read:

Subd. 3. [PREMIUM RATE RESTRICTIONS.] No individual health plan may be offered, sold, issued, or renewed to a Minnesota resident unless the premium rate charged is determined in accordance with the following requirements:

(a) Premium rates must be no more than 25 percent above and no more than 25 percent below the index rate charged to individuals for the same or similar coverage, adjusted pro rata for rating periods of less than one year. The premium variations permitted by this paragraph must be based only upon health status, claims experience, and occupation. For purposes of this paragraph, health status includes refraining from tobacco use or other actuarially valid lifestyle factors associated with good health, provided that the lifestyle factor and its effect upon premium rates have been determined by the commissioner to be actuarially valid and have been approved by the commissioner. Variations permitted under this paragraph must not be based upon age or applied differently at different ages. This paragraph does not prohibit use of a constant percentage adjustment for factors permitted to be used under this paragraph.

(b) Premium rates may vary based upon the ages of covered persons only as provided in this paragraph. In addition to the variation permitted under paragraph (a), each health carrier may use an additional premium variation based upon age of up to plus or minus 50 percent of the index rate.

(c) A health carrier may request approval by the commissioner to establish no more than three geographic regions and to establish separate index rates for each region, provided that the index rates do not vary between any two regions by more than 20 percent. Health carriers that do not do business in the Minneapolis/St. Paul metropolitan area may request approval for no more than two geographic regions, and clauses (2) and (3) do

not apply to approval of requests made by those health carriers. The commissioner may grant approval if the following conditions are met:

(1) the geographic regions must be applied uniformly by the health carrier;

(2) one geographic region must be based on the Minneapolis/St. Paul metropolitan area;

(3) for each geographic region that is rural, the index rate for that region must not exceed the index rate for the Minneapolis/St. Paul metropolitan area; and

(4) the health carrier provides actuarial justification acceptable to the commissioner for the proposed geographic variations in index rates, establishing that the variations are based upon differences in the cost to the health carrier of providing coverage.

(d) Health carriers may use rate cells and must file with the commissioner the rate cells they use. Rate cells must be based upon the number of adults or children covered under the policy and may reflect the availability of Medicare coverage. The rates for different rate cells must not in any way reflect generalized differences in expected costs between principal insureds and their spouses.

(e) In developing its index rates and premiums for a health plan, a health carrier shall take into account only the following factors:

(1) actuarially valid differences in rating factors permitted under paragraphs (a) and (b); and

(2) actuarially valid geographic variations if approved by the commissioner as provided in paragraph (c).

(f) All premium variations must be justified in initial rate filings and upon request of the commissioner in rate revision filings. All rate variations are subject to approval by the commissioner.

(g) The loss ratio must comply with the section 62A.021 requirements for individual health plans.

(h) <u>Notwithstanding paragraphs (a) to (g),</u> the rates must

not be approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risks associated with the enrollee populations~~,~~ and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549.

Sec. 2. Minnesota Statutes 2004, section 62D.12, subdivision 19, is amended to read:

Subd. 19. [COVERAGE OF SERVICE.] A health maintenance organization may not deny or limit coverage of a service which the enrollee has already received solely on the basis of lack of prior authorization or second opinion, to the extent that the service would otherwise have been covered under the member's contract by the health maintenance organization had prior authorization or second opinion been obtained. This subdivision does not apply to prior authorization under chapter 256B, 256D, or 256L.

Sec. 3. Minnesota Statutes 2004, section 62J.04, is amended by adding a subdivision to read:

Subd. 1b. [PREMIUM GROWTH LIMITS.] (a) For calendar year 2005 and each year thereafter, the commissioner shall set annual premium growth limits for health plan companies. The premium limits set by the commissioner for calendar years 2005 to 2010 shall not exceed the regional Consumer Price Index for urban consumers for the preceding calendar year plus two percentage points and an additional one percentage point to be used to finance the implementation of the electronic medical record system described under section 62J.565. The commissioner shall ensure that the additional percentage point is being used to provide financial assistance to health care providers to implement electronic medical record systems either directly or through an increase in reimbursement.

(b) For the calendar years beyond 2010, the rate of premium growth shall be limited to the change in the Consumer Price Index for urban consumers for the previous calendar year plus two percentage points. The commissioners of health and commerce shall make a recommendation to the legislature by January 15, 2009, regarding the continuation of the additional percentage point to the growth limit described in paragraph (a). The recommendation shall be based on the progress made by health care providers in instituting an electronic medical record system and in creating a statewide interactive electronic health record system.

(c) The commissioner may add additional percentage points as needed to the premium limit for a calendar year if a major disaster, bioterrorism, or a public health emergency occurs that results in higher health care costs. Any additional percentage points must reflect the additional cost to the health care system directly attributed to the disaster or emergency.

(d) The commissioner shall publish the annual premium growth limits in the State Register by January 31 of the year that the limits are to be in effect.

(e) For the purpose of this subdivision, premium growth is measured as the percentage change in per member, per month premium revenue from the current year to the previous year. Premium growth rates shall be calculated for the following lines of business: individual, small group, and large group. Data used for premium growth rate calculations shall be submitted as part of the cost containment filing under section 62J.38.

(f) For purposes of this subdivision, "health plan company," has the meaning given in section 62J.041.

(g) For coverage that is provided by a health plan company under the terms of a contract with the Department of Employee Relations, the commissioner of employee relations shall direct the contracting health plan companies to reduce reimbursement to providers in order to meet the premium growth limitations required by this section.

Sec. 4. Minnesota Statutes 2004, section 62J.04,

subdivision 3, is amended to read:

Subd. 3. [COST CONTAINMENT DUTIES.] The commissioner shall:

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

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

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

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

(5) undertake health planning responsibilities;

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

(7) within the limits of appropriations for these purposes, administer or contract for statewide consumer education and wellness programs that will improve the health of Minnesotans

and increase individual responsibility relating to personal health and the delivery of health care services, undertake prevention programs including initiatives to improve birth outcomes, expand childhood immunization efforts, and provide start-up grants for worksite wellness programs;

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

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

Sec. 5. Minnesota Statutes 2004, section 62J.041, is amended to read:

62J.041 [~~INTERIM~~ HEALTH PLAN COMPANY ~~COST-CONTAINMENT-GOALS~~ HEALTH CARE 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 and also includes employee health plans offered by self-insured employers.

(c) "~~Total~~ Health care 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, co-payment, deductible payments, and amounts in excess of benefit plan maximums.

Subd. 2. [ESTABLISHMENT.] The commissioner of health shall establish ~~cost-containment-goals~~ health care expenditure limits for ~~the-increase-in-net~~ calendar year 2006, and each year thereafter, for health care expenditures by each health plan company ~~for-calendar-years-1994,-1995,-1996,-and-1997.--The-cost containment-goals-must-be-the-same-as-the-annual-cost containment-goals-for-health-care-spending-established-under section-62J.04,-subdivision-1,-paragraph-(b)~~. Health plan companies that are affiliates may elect to meet one combined ~~cost-containment-goal~~ health care expenditure limit. The limits set by the commissioner shall not exceed the premium limits established in section 62J.04, subdivision 1b.

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~~ of each year beginning 2006, all information the commissioner determines to be necessary to implement this section. The information must be submitted in the form specified by the commissioner. The information must include, but is not limited to, health care expenditures per member per month or cost per employee per month, and detailed information on revenues and reserves. The commissioner, to the extent possible, shall coordinate the submittal of the information required under this section with the submittal of the financial data required under chapter 62J, to minimize the administrative burden on health plan companies. The commissioner may adjust final expenditure figures for demographic changes, risk selection, changes in basic benefits, and legislative initiatives that materially change health care costs, as long as these adjustments are consistent with the methodology submitted by the health plan company to the commissioner, and approved by

the commissioner as actuarially justified. ~~The methodology to be used for adjustments and the election to meet one cost containment goal for affiliated health plan companies must be submitted to the commissioner by September 1, 1994. Community integrated service networks may submit the information with their application for licensure. The commissioner shall also accept changes to methodologies already submitted. The adjustment methodology submitted and approved by the commissioner must apply to the data submitted for calendar years 1994 and 1995. The commissioner may allow changes to accepted adjustment methodologies for data submitted for calendar years 1996 and 1997. Changes to the adjustment methodology must be received by September 1, 1996, and must be approved by the commissioner.~~

Subd. 4. [MONITORING OF RESERVES.] (a) The commissioners of health and commerce shall monitor health plan company reserves and net worth as established under chapters 60A, 62C, 62D, 62H, and 64B, with respect to the health plan companies that each commissioner respectively regulates to assess the degree to which savings resulting from the establishment of cost containment goals are passed on to consumers in the form of lower premium rates.

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

(c) Health plan companies, except those licensed under chapter 60A to sell accident and sickness insurance under chapter 62A, shall annually before the end of the fourth fiscal quarter provide to the commissioner of health or commerce, as applicable, a projection of the level of reserves the company expects to attain during each quarter of the following fiscal

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

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

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

Subd. 5. [NOTICE.] The commissioner of health shall publish in the State Register and make available to the public by July 1, ~~1995~~ 2007, and each year thereafter, a list of all health plan companies that exceeded their ~~cost-containment-goal~~ health care expenditure limit for the ~~1994~~ previous calendar

year. ~~The commissioner shall publish in the State Register and make available to the public by July 1, 1996, a list of all health plan companies that exceeded their combined cost containment goal for calendar years 1994 and 1995.~~ The commissioner shall notify each health plan company that the commissioner has determined that the health plan company exceeded its ~~cost containment goal,~~ health care 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 ~~cost containment goal~~ health care 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.

Sec. 6. [62J.255] [HEALTH RISK INFORMATION SHEET.]

(a) A health plan company shall provide to each enrollee on an annual basis information on the increased personal health risks and the additional costs to the health care system due to obesity and to the use of tobacco.

(b) The commissioner, in consultation with the Minnesota Medical Association, shall develop an information sheet on the personal health risks of obesity and smoking and on the additional costs to the health care system due to obesity and due to smoking. The information sheet shall be posted on the Minnesota Department of Health's Web site.

(c) When providing the information required in paragraph (a), the health plan company must also provide each enrollee with information on the best practices care guidelines and quality of care measurement criteria identified in section 62J.43 as well as the availability of this information on the department's Web site.

Sec. 7. Minnesota Statutes 2004, section 62J.301, subdivision 3, is amended to read:

Subd. 3. [GENERAL DUTIES.] The commissioner shall:

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

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

(3) collect and maintain data for the purposes of setting cost containment goals and premium growth limits under section 62J.04, and measuring cost containment goal and premium 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.

Sec. 8. Minnesota Statutes 2004, section 62J.38, is amended to read:

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. Premium revenue data, information on aggregate enrollment, and data on member months must be broken down to distinguish between individual market, small group market, and large group market. Filings under this section for calendar year 2005 must also include information broken down by individual market, small group market, and large group market for calendar year 2004. Expenditure data must distinguish between costs incurred for patient care and administrative costs. Patient care and administrative costs must include only expenses incurred on behalf of health plan members and must not include the cost of providing health care services for nonmembers at facilities owned by the group purchaser or affiliate. Expenditure data must be provided separately for the following categories and for other categories required by the commissioner: physician services, dental services, other professional services, inpatient hospital services, outpatient hospital services, emergency, pharmacy services and other nondurable medical goods, mental health, and chemical dependency services, other expenditures, subscriber liability, and administrative costs. Administrative costs must include costs for marketing; advertising; overhead; salaries and benefits of central office staff who do not provide direct patient care; underwriting; lobbying; claims processing; provider contracting and credentialing; detection and prevention of payment for fraudulent or unjustified requests for reimbursement or services; clinical quality assurance and other types of medical care quality improvement efforts; concurrent or prospective utilization review as defined in section 62M.02; costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; capital costs incurred on behalf of a hospital or clinic; lease payments; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider. Capital costs and costs incurred must be recorded according to standard accounting principles. The reports of this data must also separately identify expenses for local,

state, and federal taxes, fees, and assessments. The commissioner may require each group purchaser to submit any other data, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, and monitoring actual spending and costs. In addition to reporting administrative costs incurred to acquire a hospital, clinic, or health care facility, or the assets thereof; or any other costs incurred pursuant to a partnership, joint venture, integration, or affiliation agreement with a hospital, clinic, or other health care provider; reports submitted under this section also must include the payments made during the calendar year for these purposes. The commissioner shall make public, by group purchaser data collected under this paragraph in accordance with section 62J.321, subdivision 5. Workers' compensation insurance plans and automobile insurance plans are exempt from complying with this paragraph as it relates to the submission of administrative costs.

(c) The commissioner may collect information on:

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

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

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

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

Sec. 9. Minnesota Statutes 2004, section 62J.692, subdivision 3, is amended to read:

Subd. 3. [APPLICATION PROCESS.] (a) A clinical medical education program conducted in Minnesota by a teaching institution to train physicians, doctor of pharmacy practitioners, dentists, chiropractors, or physician assistants is eligible for funds under subdivision 4 if the program:

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

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

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

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

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

(c) Applications must be submitted to the commissioner by a sponsoring institution on behalf of an eligible clinical medical education program and must be received by October 31 of each year for distribution in the following year. An application for funds must contain the following information:

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

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

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

those training sites that host 0.5 FTE or more eligible trainees for a program may be included in the program's application; and

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

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

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

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

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

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

Sec. 10. Minnesota Statutes 2004, section 62L.08, subdivision 8, is amended to read:

Subd. 8. [FILING REQUIREMENT.] (a) No later than July 1, 1993, and each year thereafter, a health carrier that offers, sells, issues, or renews a health benefit plan for small employers shall file with the commissioner the index rates and must demonstrate that all rates shall be within the rating restrictions defined in this chapter. Such demonstration must include the allowable range of rates from the index rates and a description of how the health carrier intends to use demographic factors including case characteristics in calculating the premium rates.

(b) Notwithstanding paragraph (a), the rates shall not be

approved~~,~~ unless the commissioner has determined that the rates are reasonable. In determining reasonableness, the commissioner shall ~~consider the growth rates applied under section 62J.04, subdivision 1, paragraph (b)~~ apply the premium growth limits established under section 62J.04, subdivision 1b, to the calendar year or years that the proposed premium rate would be in effect, and shall consider actuarially valid changes in risk associated with the enrollee population, and actuarially valid changes as a result of statutory changes in Laws 1992, chapter 549. ~~For premium rates proposed to go into effect between July 1, 1993 and December 31, 1993, the pertinent growth rate is the growth rate applied under section 62J.04, subdivision 1, paragraph (b), to calendar year 1994.~~

Sec. 11. [62Q.175] [COVERAGE EXEMPTIONS.]

Notwithstanding any law to the contrary, no health plan company is required to provide coverage for any health care service included on the list established under section 256B.0625, subdivision 46.

Sec. 12. Minnesota Statutes 2004, section 144.1501, subdivision 2, is amended to read:

Subd. 2. [CREATION OF ACCOUNT.] (a) A health professional education loan forgiveness program account is established. The commissioner of health shall use money from the account to establish a loan forgiveness program:

(1) for medical residents agreeing to practice in designated rural areas or underserved urban communities~~,~~ or specializing in the area of pediatric psychiatry;

(2) for midlevel practitioners agreeing to practice in designated rural areas~~,~~; and

(3) for nurses who agree to practice in a Minnesota nursing home or intermediate care facility for persons with mental retardation or related conditions.

(b) Appropriations made to the account do not cancel and are available until expended, except that at the end of each biennium, any remaining balance in the account that is not committed by contract and not needed to fulfill existing

commitments shall cancel to the fund.

Sec. 13. Minnesota Statutes 2004, section 144.1501, subdivision 4, is amended to read:

Subd. 4. [LOAN FORGIVENESS.] The commissioner of health may select applicants each year for participation in the loan forgiveness program, within the limits of available funding. The commissioner shall distribute available funds for loan forgiveness proportionally among the eligible professions according to the vacancy rate for each profession in the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2. The commissioner shall allocate funds for physician loan forgiveness so that ~~75~~ 50 percent of the funds available are used for rural physician loan forgiveness ~~and~~, 25 percent of the funds available are used for underserved urban communities loan forgiveness, and 25 percent of the funds available are used for pediatric psychiatry loan forgiveness. If the commissioner does not receive enough qualified applicants each year to use the entire allocation of funds for urban underserved communities, the remaining funds may be allocated for rural physician loan forgiveness. Applicants are responsible for securing their own qualified educational loans. The commissioner shall select participants based on their suitability for practice serving the required geographic area ~~or~~, facility type, or specialty area specified in subdivision 2, as indicated by experience or training. The commissioner shall give preference to applicants closest to completing their training. For each year that a participant meets the service obligation required under subdivision 3, up to a maximum of four years, the commissioner shall make annual disbursements directly to the participant equivalent to 15 percent of the average educational debt for indebted graduates in their profession in the year closest to the applicant's selection for which information is available, not to exceed the balance of the participant's qualifying educational loans. Before receiving loan repayment disbursements and as requested, the participant must complete and return to the commissioner an

affidavit of practice form provided by the commissioner verifying that the participant is practicing as required under subdivisions 2 and 3. The participant must provide the commissioner with verification that the full amount of loan repayment disbursement received by the participant has been applied toward the designated loans. After each disbursement, verification must be received by the commissioner and approved before the next loan repayment disbursement is made. Participants who move their practice remain eligible for loan repayment as long as they practice as required under subdivision 2.

Sec. 14. Minnesota Statutes 2004, section 256.045, subdivision 3a, is amended to read:

Subd. 3a. [PREPAID HEALTH PLAN APPEALS.] (a) All prepaid health plans under contract to the commissioner under chapter 256B or 256D must provide for a complaint system according to section 62D.11. When a prepaid health plan denies, reduces, or terminates a health service or denies a request to authorize a previously authorized health service, the prepaid health plan must notify the recipient of the right to file a complaint or an appeal. The notice must include the name and telephone number of the ombudsman and notice of the recipient's right to request a hearing under paragraph (b). When a complaint is filed, the prepaid health plan must notify the ombudsman within three working days. Recipients may request the assistance of the ombudsman in the complaint system process. The prepaid health plan must issue a written resolution of the complaint to the recipient within 30 days after the complaint is filed with the prepaid health plan. A recipient is not required to exhaust the complaint system procedures in order to request a hearing under paragraph (b).

(b) Recipients enrolled in a prepaid health plan under chapter 256B or 256D may contest a prepaid health plan's denial, reduction, or termination of health services, a prepaid health plan's denial of a request to authorize a previously authorized health service, or the prepaid health plan's written resolution

of a complaint by submitting a written request for a hearing according to subdivision 3. A state human services referee shall conduct a hearing on the matter and shall recommend an order to the commissioner of human services. The referee may not overturn a decision on prior authorization for services covered under section 28, if the prepaid health plan has appropriately used evidence-based criteria or guidelines in making the determination. The commissioner need not grant a hearing if the sole issue raised by a recipient is the commissioner's authority to require mandatory enrollment in a prepaid health plan in a county where prepaid health plans are under contract with the commissioner. The state human services referee may order a second medical opinion from the prepaid health plan or may order a second medical opinion from a nonprepaid health plan provider at the expense of the prepaid health plan. Recipients may request the assistance of the ombudsman in the appeal process.

(c) In the written request for a hearing to appeal from a prepaid health plan's denial, reduction, or termination of a health service, a prepaid health plan's denial of a request to authorize a previously authorized service, or the prepaid health plan's written resolution to a complaint, a recipient may request an expedited hearing. If an expedited appeal is warranted, the state human services referee shall hear the appeal and render a decision within a time commensurate with the level of urgency involved, based on the individual circumstances of the case.

Sec. 15. [256.9545] [PRESCRIPTION DRUG DISCOUNT PROGRAM.]

Subdivision 1. [ESTABLISHMENT; ADMINISTRATION.] The commissioner shall establish and administer the prescription drug discount program, effective July 1, 2005.

Subd. 2. [COMMISSIONER'S AUTHORITY.] The commissioner shall administer a drug rebate program for drugs purchased according to the prescription drug discount program. The commissioner shall require a rebate agreement from all manufacturers of covered drugs as defined in section 256B.0625,

subdivision 13. For each drug, the amount of the rebate shall be equal to the rebate as defined for purposes of the federal rebate program in United States Code, title 42, section 1396r-8. The rebate program shall utilize the terms and conditions used for the federal rebate program established according to section 1927 of title XIX of the federal Social Security Act.

Subd. 3. [DEFINITIONS.] For the purpose of this section, the following terms have the meanings given them.

(a) "Commissioner" means the commissioner of human services.

(b) "Manufacturer" means a manufacturer as defined in section 151.44, paragraph (c).

(c) "Covered prescription drug" means a prescription drug as defined in section 151.44, paragraph (d), that is covered under medical assistance as described in section 256B.0625, subdivision 13, and that is provided by a manufacturer that has a fully executed rebate agreement with the commissioner under this section and complies with that agreement.

(d) "Health carrier" means an insurance company licensed under chapter 60A to offer, sell, or issue an individual or group policy of accident and sickness insurance as defined in section 62A.01; a nonprofit health service plan corporation operating under chapter 62C; a health maintenance organization operating under chapter 62D; a joint self-insurance employee health plan operating under chapter 62H; a community integrated systems network licensed under chapter 62N; a fraternal benefit society operating under chapter 64B; a city, county, school district, or other political subdivision providing self-insured health coverage under section 471.617 or sections 471.98 to 471.982; and a self-funded health plan under the Employee Retirement Income Security Act of 1974, as amended.

(e) "Participating pharmacy" means a pharmacy as defined in section 151.01, subdivision 2, that agrees to participate in the prescription drug discount program.

(f) "Enrolled individual" means a person who is eligible for the program under subdivision 4 and has enrolled in the

program according to subdivision 5.

Subd. 4. [ELIGIBLE PERSONS.] To be eligible for the program, an applicant must:

(1) be a permanent resident of Minnesota as defined in section 256L.09, subdivision 4;

(2) not be enrolled in Medicare, medical assistance, general assistance medical care, or MinnesotaCare;

(3) not be enrolled in and have currently available prescription drug coverage under a health plan offered by a health carrier or employer or under a pharmacy benefit program offered by a pharmaceutical manufacturer; and

(4) not be enrolled in and have currently available prescription drug coverage 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 1876 of the federal Social Security Act, United States Code, title 42, section 1395, et seq., as amended.

Subd. 5. [APPLICATION PROCEDURE.] (a) Applications and information on the program must be made available at county social services agencies, health care provider offices, and agencies and organizations serving senior citizens. Individuals shall submit applications and any information specified by the commissioner as being necessary to verify eligibility directly to the commissioner. The commissioner shall determine an applicant's eligibility for the program within 30 days from the date the application is received. Upon notice of approval, the applicant must submit to the commissioner the enrollment fee specified in subdivision 10. Eligibility begins the month after the enrollment fee is received by the commissioner.

(b) An enrollee's eligibility must be renewed every 12 months with the 12-month period beginning in the month after the application is approved.

(c) The commissioner shall develop an application form that does not exceed one page in length and requires information

necessary to determine eligibility for the program.

Subd. 6. [PARTICIPATING PHARMACY.] According to a valid prescription, a participating pharmacy must sell a covered prescription drug to an enrolled individual at the pharmacy's usual and customary retail price, minus an amount that is equal to the rebate amount described in subdivision 8, plus the amount of any switch fee established by the commissioner under subdivision 10. Each participating pharmacy shall provide the commissioner with all information necessary to administer the program, including, but not limited to, information on prescription drug sales to enrolled individuals and usual and customary retail prices.

Subd. 7. [NOTIFICATION OF REBATE AMOUNT.] The commissioner shall notify each drug manufacturer, each calendar quarter or according to a schedule to be established by the commissioner, of the amount of the rebate owed on the prescription drugs sold by participating pharmacies to enrolled individuals.

Subd. 8. [PROVISION OF REBATE.] To the extent that a manufacturer's prescription drugs are prescribed to a resident of this state, the manufacturer must provide a rebate equal to the rebate provided under the medical assistance program for any prescription drug distributed by the manufacturer that is purchased by an enrolled individual at a participating pharmacy. The manufacturer must provide full payment within 30 days of receipt of the state invoice for the rebate, or according to a schedule to be established by the commissioner. The commissioner shall deposit all rebates received into the Minnesota prescription drug dedicated fund established under subdivision 11. The manufacturer must provide the commissioner with any information necessary to verify the rebate determined per drug.

Subd. 9. [PAYMENT TO PHARMACIES.] The commissioner shall distribute on a biweekly basis an amount that is equal to an amount collected under subdivision 8 to each participating pharmacy based on the prescription drugs sold by that pharmacy to enrolled individuals.

Subd. 10. [ENROLLMENT FEE; SWITCH FEE.] (a) The commissioner shall establish an annual enrollment fee that covers the commissioner's expenses for enrollment, processing claims, and distributing rebates under this program.

(b) The commissioner shall establish a reasonable switch fee that covers expenses incurred by pharmacies in formatting for electronic submission claims for prescription drugs sold to enrolled individuals.

Subd. 11. [DEDICATED FUND; CREATION; USE OF FUND.] (a) The Minnesota prescription drug dedicated fund is established as an account in the state treasury. The commissioner of finance shall credit to the dedicated fund all rebates paid under subdivision 8, any federal funds received for the program, all enrollment fees paid by the enrollees, and any appropriations or allocations designated for the fund. The commissioner of finance shall ensure that fund money is invested under section 11A.25. All money earned by the fund must be credited to the fund. The fund shall earn a proportionate share of the total state annual investment income.

(b) Money in the fund is appropriated to the commissioner to reimburse participating pharmacies for prescription drug discounts provided to enrolled individuals under this section; to reimburse the commissioner for costs related to enrollment, processing claims, and distributing rebates and for other reasonable administrative costs related to administration of the prescription drug discount program; and to repay the appropriation provided for this section. The commissioner must administer the program so that the costs total no more than funds appropriated plus the drug rebate proceeds.

Sec. 16. Minnesota Statutes 2004, section 256.9693, is amended to read:

256.9693 [CONTINUING CARE PROGRAM FOR PERSONS WITH MENTAL ILLNESS.]

The commissioner shall establish a continuing care benefit program for persons with mental illness in which persons with mental illness may obtain acute care hospital inpatient

treatment for mental illness for up to 45 days beyond that allowed by section 256.969. Persons with mental illness who are eligible for medical assistance or general assistance medical care may obtain inpatient treatment under this program in hospital beds for which the commissioner contracts under this section. The commissioner may selectively contract with hospitals to provide this benefit through competitive bidding when reasonable geographic access by recipients can be assured. Payments under this section shall not affect payments under section 256.969. The commissioner may contract externally with a utilization review organization to authorize persons with mental illness to access the continuing care benefit program. The commissioner, as part of the contracts with hospitals, shall establish admission criteria to allow persons with mental illness to access the continuing care benefit program. If a court orders acute care hospital inpatient treatment for mental illness for a person, the person may obtain the treatment under the continuing care benefit program. The commissioner shall not require, as part of the admission criteria, any commitment or petition under chapter 253B as a condition of accessing the program. This benefit is not available for people who are also eligible for Medicare and who have not exhausted their annual or lifetime inpatient psychiatric benefit under Medicare. If a recipient is enrolled in a prepaid plan, this program is included in the plan's coverage.

Sec. 17. Minnesota Statutes 2004, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. [TELEMEDICINE CONSULTATIONS.] Medical assistance covers telemedicine consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine

consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation, unless the communication is between a pediatrician and psychiatrist for the purpose of managing the medications of a child with mental health needs. Coverage is limited to three telemedicine consultations per recipient per calendar week. Telemedicine consultations shall be paid at the full allowable rate.

Sec. 18. Minnesota Statutes 2004, section 256B.0625, is amended by adding a subdivision to read:

Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR COVERAGE.] (a) The commissioner of human services, in consultation with the commissioner of health, shall biennially establish a list of diagnosis/treatment pairings that are not eligible for reimbursement under this chapter and chapters 256D and 256L, effective for services provided on or after July 1, 2007. The commissioner shall review the list in effect for the prior biennium and shall make any additions or deletions from the list as appropriate, taking into consideration the following:

(1) scientific and medical information;

(2) clinical assessment;

(3) cost-effectiveness of treatment;

(4) prevention of future costs; and

(5) medical ineffectiveness.

(b) The commissioner may appoint an ad hoc advisory panel made up of physicians, consumers, nurses, dentists, chiropractors, and other experts to assist the commissioner in reviewing and establishing the list. The commissioner shall solicit comments and recommendations from any interested persons and organizations and shall schedule at least one public hearing.

(c) The list must be established by January 15, 2007, for the list effective July 1, 2007, and by October 1 of the even-numbered years beginning October 1, 2008, for the lists effective the following July 1. The commissioner shall publish the list in the State Register by November 1 of the even-numbered years beginning November 1, 2008. The list shall

be submitted to the legislature by January 15 of the odd-numbered years beginning January 15, 2007.

Sec. 19. Minnesota Statutes 2004, section 256B.0627, subdivision 1, is amended to read:

Subdivision 1. [DEFINITION.] (a) "Activities of daily living" includes eating, toileting, grooming, dressing, bathing, transferring, mobility, and positioning.

(b) "Assessment" means a review and evaluation of a recipient's need for home care services conducted in person. Assessments for private duty nursing shall be conducted by a registered private duty nurse. Assessments for home health agency services shall be conducted by a home health agency nurse. Assessments for personal care assistant services shall be conducted by the county public health nurse or a certified public health nurse under contract with the county. A face-to-face assessment must include: documentation of health status, determination of need, evaluation of service effectiveness, identification of appropriate services, service plan development or modification, coordination of services, referrals and follow-up to appropriate payers and community resources, completion of required reports, recommendation of service authorization, and consumer education. Once the need for personal care assistant services is determined under this section, the county public health nurse or certified public health nurse under contract with the county is responsible for communicating this recommendation to the commissioner and the recipient. A face-to-face assessment for personal care assistant services is conducted on those recipients who have never had a county public health nurse assessment. A face-to-face assessment must occur at least annually or when there is a significant change in the recipient's condition or when there is a change in the need for personal care assistant services. A service update may substitute for the annual face-to-face assessment when there is not a significant change in recipient condition or a change in the need for personal care assistant service. A service update or review for temporary

increase includes a review of initial baseline data, evaluation of service effectiveness, redetermination of service need, modification of service plan and appropriate referrals, update of initial forms, obtaining service authorization, and on going consumer education. Assessments for medical assistance home care services for mental retardation or related conditions and alternative care services for developmentally disabled home and community-based waivered recipients may be conducted by the county public health nurse to ensure coordination and avoid duplication. Assessments must be completed on forms provided by the commissioner within 30 days of a request for home care services by a recipient or responsible party. Assessments shall not be conducted by the same agency, individual, or organization providing the care services.

(c) "Care plan" means a written description of personal care assistant services developed by the qualified professional or the recipient's physician with the recipient or responsible party to be used by the personal care assistant with a copy provided to the recipient or responsible party.

(d) "Complex and regular private duty nursing care" means:

(1) complex care is private duty nursing provided to recipients who are ventilator dependent or for whom a physician has certified that were it not for private duty nursing the recipient would meet the criteria for inpatient hospital intensive care unit (ICU) level of care; and

(2) regular care is private duty nursing provided to all other recipients.

(e) "Health-related functions" means functions that can be delegated or assigned by a licensed health care professional under state law to be performed by a personal care attendant.

(f) "Home care services" means a health service, determined by the commissioner as medically necessary, that is ordered by a physician and documented in a service plan that is reviewed by the physician at least once every 60 days for the provision of home health services, or private duty nursing, or at least once every 365 days for personal care. Home care services are

provided to the recipient at the recipient's residence that is a place other than a hospital or long-term care facility or as specified in section 256B.0625.

(g) "Instrumental activities of daily living" includes meal planning and preparation, managing finances, shopping for food, clothing, and other essential items, performing essential household chores, communication by telephone and other media, and getting around and participating in the community.

(h) "Medically necessary" has the meaning given in Minnesota Rules, parts 9505.0170 to 9505.0475.

(i) "Personal care assistant" means a person who:

(1) is at least 18 years old, except for persons 16 to 18 years of age who participated in a related school-based job training program or have completed a certified home health aide competency evaluation;

(2) is able to effectively communicate with the recipient and personal care provider organization;

(3) effective July 1, 1996, has completed one of the training requirements as specified in Minnesota Rules, part 9505.0335, subpart 3, items A to D;

(4) has the ability to, and provides covered personal care assistant services according to the recipient's care plan, responds appropriately to recipient needs, and reports changes in the recipient's condition to the supervising qualified professional or physician;

(5) is not a consumer of personal care assistant services; and

(6) is subject to criminal background checks and procedures specified in chapter 245C.

(j) "Personal care provider organization" means an organization enrolled to provide personal care assistant services under the medical assistance program that complies with the following: (1) owners who have a five percent interest or more, and managerial officials are subject to a background study as provided in chapter 245C. This applies to currently enrolled personal care provider organizations and those agencies seeking

enrollment as a personal care provider organization. An organization will be barred from enrollment if an owner or managerial official of the organization has been convicted of a crime specified in chapter 245C, or a comparable crime in another jurisdiction, unless the owner or managerial official meets the reconsideration criteria specified in chapter 245C; (2) the organization must maintain a surety bond and liability insurance throughout the duration of enrollment and provides proof thereof. The insurer must notify the Department of Human Services of the cancellation or lapse of policy; and (3) the organization must maintain documentation of services as specified in Minnesota Rules, part 9505.2175, subpart 7, as well as evidence of compliance with personal care assistant training requirements.

(k) "Responsible party" means an individual who is capable of providing the support necessary to assist the recipient to live in the community, is at least 18 years old, actively participates in planning and directing of personal care assistant services, and is not the personal care assistant. The responsible party must be accessible to the recipient and the personal care assistant when personal care services are being provided and monitor the services at least weekly according to the plan of care. The responsible party must be identified at the time of assessment and listed on the recipient's service agreement and care plan. Responsible parties who are parents of minors or guardians of minors or incapacitated persons may delegate the responsibility to another adult ~~who is not the personal care assistant~~ during a temporary absence of at least 24 hours but not more than six months. The person delegated as a responsible party must be able to meet the definition of responsible party, except that the delegated responsible party is required to reside with the recipient only while serving as the responsible party. The responsible party must assure that the delegate performs the functions of the responsible party, is identified at the time of the assessment, and is listed on the service agreement and the care plan. Foster care license

holders may be designated the responsible party for residents of the foster care home if case management is provided as required in section 256B.0625, subdivision 19a. For persons who, as of April 1, 1992, are sharing personal care assistant services in order to obtain the availability of 24-hour coverage, an employee of the personal care provider organization may be designated as the responsible party if case management is provided as required in section 256B.0625, subdivision 19a.

(l) "Service plan" means a written description of the services needed based on the assessment developed by the nurse who conducts the assessment together with the recipient or responsible party. The service plan shall include a description of the covered home care services, frequency and duration of services, and expected outcomes and goals. The recipient and the provider chosen by the recipient or responsible party must be given a copy of the completed service plan within 30 calendar days of the request for home care services by the recipient or responsible party.

(m) "Skilled nurse visits" are provided in a recipient's residence under a plan of care or service plan that specifies a level of care which the nurse is qualified to provide. These services are:

(1) nursing services according to the written plan of care or service plan and accepted standards of medical and nursing practice in accordance with chapter 148;

(2) services which due to the recipient's medical condition may only be safely and effectively provided by a registered nurse or a licensed practical nurse;

(3) assessments performed only by a registered nurse; and

(4) teaching and training the recipient, the recipient's family, or other caregivers requiring the skills of a registered nurse or licensed practical nurse.

(n) "Telehomecare" means the use of telecommunications technology by a home health care professional to deliver home health care services, within the professional's scope of practice, to a patient located at a site other than the site

where the practitioner is located.

Sec. 20. Minnesota Statutes 2004, section 256B.0627, subdivision 4, is amended to read:

Subd. 4. [PERSONAL CARE ASSISTANT SERVICES.] (a) The personal care assistant services that are eligible for payment are services and supports furnished to an individual, as needed, to assist in accomplishing activities of daily living; instrumental activities of daily living; health-related functions through hands-on assistance, supervision, and cuing; and redirection and intervention for behavior including observation and monitoring.

(b) Payment for services will be made within the limits approved using the prior authorized process established in subdivision 5.

(c) The amount and type of services authorized shall be based on an assessment of the recipient's needs in these areas:

(1) bowel and bladder care;

(2) skin care to maintain the health of the skin;

(3) repetitive maintenance range of motion, muscle strengthening exercises, and other tasks specific to maintaining a recipient's optimal level of function;

(4) respiratory assistance;

(5) transfers and ambulation;

(6) bathing, grooming, and hairwashing necessary for personal hygiene;

(7) turning and positioning;

(8) assistance with furnishing medication that is self-administered;

(9) application and maintenance of prosthetics and orthotics;

(10) cleaning medical equipment;

(11) dressing or undressing;

(12) assistance with eating and meal preparation and necessary grocery shopping;

(13) accompanying a recipient to obtain medical diagnosis or treatment;

(14) assisting, monitoring, or prompting the recipient to complete the services in clauses (1) to (13);

(15) redirection, monitoring, and observation that are medically necessary and an integral part of completing the personal care assistant services described in clauses (1) to (14);

(16) redirection and intervention for behavior, including observation and monitoring;

(17) interventions for seizure disorders, including monitoring and observation if the recipient has had a seizure that requires intervention within the past three months;

(18) tracheostomy suctioning using a clean procedure if the procedure is properly delegated by a registered nurse. Before this procedure can be delegated to a personal care assistant, a registered nurse must determine that the tracheostomy suctioning can be accomplished utilizing a clean rather than a sterile procedure and must ensure that the personal care assistant has been taught the proper procedure; and

(19) incidental household services that are an integral part of a personal care service described in clauses (1) to (18). For purposes of this subdivision, monitoring and observation means watching for outward visible signs that are likely to occur and for which there is a covered personal care service or an appropriate personal care intervention. For purposes of this subdivision, a clean procedure refers to a procedure that reduces the numbers of microorganisms or prevents or reduces the transmission of microorganisms from one person or place to another. A clean procedure may be used beginning 14 days after insertion.

(d) The personal care assistant services that are not eligible for payment are the following:

(1) services not ordered by the physician;

(2) assessments by personal care assistant provider organizations or by independently enrolled registered nurses;

(3) services that are not in the service plan;

(4) services provided by the recipient's spouse, legal

guardian for an adult or child recipient, or parent of a recipient under age 18;

(5) services provided by a foster care provider of a recipient who cannot direct the recipient's own care, unless monitored by a county or state case manager under section 256B.0625, subdivision 19a;

(6) services provided by the residential or program license holder in a residence for more than four persons;

(7) services that are the responsibility of a residential or program license holder under the terms of a service agreement and administrative rules;

(8) sterile procedures;

(9) injections of fluids into veins, muscles, or skin;

(10) services provided by parents of adult recipients, adult children, or siblings of the recipient, unless these relatives meet one of the following hardship criteria and the commissioner waives this requirement:

(i) the relative resigns from a part-time or full-time job to provide personal care for the recipient;

(ii) the relative goes from a full-time to a part-time job with less compensation to provide personal care for the recipient;

(iii) the relative takes a leave of absence without pay to provide personal care for the recipient;

(iv) the relative incurs substantial expenses by providing personal care for the recipient; or

(v) because of labor conditions, special language needs, or intermittent hours of care needed, the relative is needed in order to provide an adequate number of qualified personal care assistants to meet the medical needs of the recipient;

(11) homemaker services that are not an integral part of a personal care assistant services;

~~(11)~~ (12) home maintenance or chore services;

~~(12)~~ (13) services not specified under paragraph (a); and

~~(13)~~ (14) services not authorized by the commissioner or the commissioner's designee.

(e) The recipient or responsible party may choose to supervise the personal care assistant or to have a qualified professional, as defined in section 256B.0625, subdivision 19c, provide the supervision. As required under section 256B.0625, subdivision 19c, the county public health nurse, as a part of the assessment, will assist the recipient or responsible party to identify the most appropriate person to provide supervision of the personal care assistant. Health-related delegated tasks performed by the personal care assistant will be under the supervision of a qualified professional or the direction of the recipient's physician. If the recipient has a qualified professional, Minnesota Rules, part 9505.0335, subpart 4, applies.

(f) The commissioner shall establish an ongoing audit process for potential fraud and abuse for personal care assistant services.

Sec. 21. Minnesota Statutes 2004, section 256B.0627, subdivision 9, is amended to read:

Subd. 9. [FLEXIBLE USE OF PERSONAL CARE ASSISTANT HOURS.] (a) The commissioner may allow for the flexible use of personal care assistant hours. "Flexible use" means the scheduled use of authorized hours of personal care assistant services, which vary within the length of the service authorization in order to more effectively meet the needs and schedule of the recipient. Recipients may use their approved hours flexibly within the service authorization period for medically necessary covered services specified in the assessment required in subdivision 1. The flexible use of authorized hours does not increase the total amount of authorized hours available to a recipient as determined under subdivision 5. The commissioner shall not authorize additional personal care assistant services to supplement a service authorization that is exhausted before the end date under a flexible service use plan, unless the county public health nurse determines a change in condition and a need for increased services is established.

(b) The recipient or responsible party together with the

county public health nurse, shall determine whether flexible use is an appropriate option based on the needs and preferences of the recipient or responsible party, and, if appropriate, must ensure that the allocation of hours covers the ongoing needs of the recipient over the entire service authorization period. As part of the assessment and service planning process, the recipient or responsible party must work with the county public health nurse to develop a written month-to-month plan of the projected use of personal care assistant services that is part of the service plan and ensures that the:

(1) health and safety needs of the recipient will be met;

(2) total annual authorization will not exceed before the end date; and

(3) how actual use of hours will be monitored.

(c) If the actual use of personal care assistant service varies significantly from the use projected in the plan, the written plan must be promptly updated by the recipient or responsible party and the county public health nurse.

(d) The recipient or responsible party, together with the provider, must work to monitor and document the use of authorized hours and ensure that a recipient is able to manage services effectively throughout the authorized period. The provider must ensure that the month-to-month plan is incorporated into the care plan. Upon request of the recipient or responsible party, the provider must furnish regular updates to the recipient or responsible party on the amount of personal care assistant services used.

(e) The recipient or responsible party may revoke the authorization for flexible use of hours by notifying the provider and county public health nurse in writing.

(f) If the requirements in paragraphs (a) to (e) have not substantially been met, the commissioner shall deny, revoke, or suspend the authorization to use authorized hours flexibly. The recipient or responsible party may appeal the commissioner's action according to section 256.045. The denial, revocation, or suspension to use the flexible hours option shall not affect the

recipient's authorized level of personal care assistant services as determined under subdivision 5.

Sec. 22. Minnesota Statutes 2004, section 256B.0631, is amended by adding a subdivision to read:

Subd. 5. [HEALTHY LIFESTYLE WAIVER.] The co-payments described in subdivision 1 shall be waived by the provider if the recipient is practicing a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

Sec. 23. [256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT PAYMENT SYSTEM.]

(a) The commissioner of human services shall establish a performance reporting and payment system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L.

(b) The measures used for the performance reporting and payment system for medical groups or single-physician practices shall include, but are not limited to, measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting and payment system for inpatient hospitals shall include, but are not limited to, measures of care for acute myocardial infarction, heart failure, and pneumonia, measures of care and prevention of surgical infections. In the case of a medical group or single-physician practice, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or evidence-based health care guidelines. In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to develop the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the

commissioner may use measures of care provided for patients in addition to those identified in paragraph (a). The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) For recipients seen on or after January 1, 2007, the commissioner shall provide a performance bonus payment to providers who have achieved certain levels of performance established by the commissioner with respect to the measures or who have achieved certain rates of improvement established by the commissioner with respect to the measures or whose rates of achievement have increased over a previous period, as established by the commissioner. The performance bonus payment may be a fixed dollar amount per patient, paid quarterly or annually, or alternatively payment may be made as a percentage increase over payments allowed elsewhere in statute for the recipients identified in paragraph (a). In order for providers to be eligible for a performance bonus payment under this section, the commissioner may require the providers to submit information in a required format to a health care reporting organization or to cooperate with the information collection procedures of that organization. The commissioner may contract with a reporting organization to assist with the collection of reporting information and to prevent duplication of reporting. The commissioner may limit application of the performance bonus payment system to providers that provide a sufficiently large volume of care to permit adequate statistical precision in the measurement of that care, as established by the commissioner, after consulting with other health care quality reporting organizations.

(d) The performance bonus payments shall be funded with the projected savings in the program costs due to improved results of these measures with the eligible providers.

(e) The commissioner shall publish a description of the proposed performance reporting and payment system for the

calendar year beginning January 1, 2007, and each subsequent calendar year, at least three months prior to the beginning of that calendar year.

(f) By April 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical group, single-physician practice, and hospital of the measures and the performance payments under this section, and shall compare the results by medical group, single-physician practice, and hospital for patients enrolled in public programs to patients enrolled in private health plans. To achieve this reporting, the commissioner may contract with a health care reporting organization that operates a Web site suitable for this purpose.

Sec. 24. [256B.0918] [EMPLOYEE SCHOLARSHIP COSTS AND TRAINING IN ENGLISH AS A SECOND LANGUAGE.]

(a) For the fiscal year beginning July 1, 2005, the commissioner shall provide to each provider listed in paragraph (c) a scholarship reimbursement increase of two-tenths percent of the reimbursement rate for that provider to be used:

(1) for employee scholarships that satisfy the following requirements:

(i) scholarships are available to all employees who work an average of at least 20 hours per week for the provider, except administrators, department supervisors, and registered nurses; and

(ii) the course of study is expected to lead to career advancement with the provider or in long-term care, including home care or care of persons with disabilities, including medical care interpreter services and social work; and

(2) to provide job-related training in English as a second language.

(b) A provider receiving a rate adjustment under this subdivision with an annualized value of at least $1,000 shall maintain documentation to be submitted to the commissioner on a schedule determined by the commissioner and on a form supplied by the commissioner of the scholarship rate increase received,

including:

(1) the amount received from this reimbursement increase;

(2) the amount used for training in English as a second language;

(3) the number of persons receiving the training;

(4) the name of the person or entity providing the training; and

(5) for each scholarship recipient, the name of the recipient, the amount awarded, the educational institution attended, the nature of the educational program, the program completion date, and a determination of the amount spent as a percentage of the provider's reimbursement.

The commissioner shall report to the legislature annually, beginning January 15, 2006, with information on the use of these funds.

(c) The rate increases described in this section shall be provided to home and community-based waivered services for persons with mental retardation or related conditions under section 256B.501; home and community-based waivered services for the elderly under section 256B.0915; waivered services under community alternatives for disabled individuals under section 256B.49; community alternative care waivered services under section 256B.49; traumatic brain injury waivered services under section 256B.49; nursing services and home health services under section 256B.0625, subdivision 6a; personal care services and nursing supervision of personal care services under section 256B.0625, subdivision 19a; private duty nursing services under section 256B.0625, subdivision 7; day training and habilitation services for adults with mental retardation or related conditions under sections 252.40 to 252.46; alternative care services under section 256B.0913; adult residential program grants under Minnesota Rules, parts 9535.2000 to 9535.3000; semi-independent living services (SILS) under section 252.275, including SILS funding under county social services grants formerly funded under chapter 256I; community support services for deaf and hard-of-hearing adults with mental illness who use

or wish to use sign language as their primary means of communication; the group residential housing supplementary service rate under section 256I.05, subdivision 1a; chemical dependency residential and nonresidential service providers under section 254B.03; and intermediate care facilities for persons with mental retardation under section 256B.5012.

(d) These increases shall be included in the provider's reimbursement rate for the purpose of determining future rates for the provider.

Sec. 25. Minnesota Statutes 2004, section 256D.03, subdivision 4, is amended to read:

Subd. 4. [GENERAL ASSISTANCE MEDICAL CARE; SERVICES.] (a)(i) For a person who is eligible under subdivision 3, paragraph (a), clause (2), item (i), general assistance medical care covers, except as provided in paragraph (c):

(1) inpatient hospital services;

(2) outpatient hospital services;

(3) services provided by Medicare certified rehabilitation agencies;

(4) prescription drugs and other products recommended through the process established in section 256B.0625, subdivision 13;

(5) equipment necessary to administer insulin and diagnostic supplies and equipment for diabetics to monitor blood sugar level;

(6) eyeglasses and eye examinations provided by a physician or optometrist;

(7) hearing aids;

(8) prosthetic devices;

(9) laboratory and X-ray services;

(10) physician's services;

(11) medical transportation except special transportation;

(12) chiropractic services as covered under the medical assistance program;

(13) podiatric services;

(14) dental services and dentures, subject to the

limitations specified in section 256B.0625, subdivision 9;

(15) outpatient services provided by a mental health center or clinic that is under contract with the county board and is established under section 245.62;

(16) day treatment services for mental illness provided under contract with the county board;

(17) prescribed medications for persons who have been diagnosed as mentally ill as necessary to prevent more restrictive institutionalization;

(18) psychological services, medical supplies and equipment, and Medicare premiums, coinsurance and deductible payments;

(19) medical equipment not specifically listed in this paragraph when the use of the equipment will prevent the need for costlier services that are reimbursable under this subdivision;

(20) services performed by a certified pediatric nurse practitioner, a certified family nurse practitioner, a certified adult nurse practitioner, a certified obstetric/gynecological nurse practitioner, a certified neonatal nurse practitioner, or a certified geriatric nurse practitioner in independent practice, if (1) the service is otherwise covered under this chapter as a physician service, (2) the service provided on an inpatient basis is not included as part of the cost for inpatient services included in the operating payment rate, and (3) the service is within the scope of practice of the nurse practitioner's license as a registered nurse, as defined in section 148.171;

(21) services of a certified public health nurse or a registered nurse practicing in a public health nursing clinic that is a department of, or that operates under the direct authority of, a unit of government, if the service is within the scope of practice of the public health nurse's license as a registered nurse, as defined in section 148.171; and

(22) telemedicine consultations, to the extent they are covered under section 256B.0625, subdivision 3b.

(ii) Effective October 1, 2003, for a person who is eligible under subdivision 3, paragraph (a), clause (2), item (ii), general assistance medical care coverage is limited to inpatient hospital services, including physician services provided during the inpatient hospital stay. A $1,000 deductible is required for each inpatient hospitalization.

(b) Gender reassignment surgery and related services are not covered services under this subdivision unless the individual began receiving gender reassignment services prior to July 1, 1995.

(c) In order to contain costs, the commissioner of human services shall select vendors of medical care who can provide the most economical care consistent with high medical standards and shall where possible contract with organizations on a prepaid capitation basis to provide these services. The commissioner shall consider proposals by counties and vendors for prepaid health plans, competitive bidding programs, block grants, or other vendor payment mechanisms designed to provide services in an economical manner or to control utilization, with safeguards to ensure that necessary services are provided. Before implementing prepaid programs in counties with a county operated or affiliated public teaching hospital or a hospital or clinic operated by the University of Minnesota, the commissioner shall consider the risks the prepaid program creates for the hospital and allow the county or hospital the opportunity to participate in the program in a manner that reflects the risk of adverse selection and the nature of the patients served by the hospital, provided the terms of participation in the program are competitive with the terms of other participants considering the nature of the population served. Payment for services provided pursuant to this subdivision shall be as provided to medical assistance vendors of these services under sections 256B.02, subdivision 8, and 256B.0625. For payments made during fiscal year 1990 and later years, the commissioner shall consult with an independent actuary in establishing prepayment rates, but shall retain final control over the rate methodology.

(d) Recipients eligible under subdivision 3, paragraph (a), clause (2), item (i), shall pay the following co-payments for services provided on or after October 1, 2003:

(1) $3 per nonpreventive visit. For purposes of this subdivision, a visit means an episode of service which is required because of a recipient's symptoms, diagnosis, or established illness, and which is delivered in an ambulatory setting by a physician or physician ancillary, chiropractor, podiatrist, nurse midwife, advanced practice nurse, audiologist, optician, or optometrist;

(2) $25 for eyeglasses;

(3) $25 for nonemergency visits to a hospital-based emergency room;

(4) $3 per brand-name drug prescription and $1 per generic drug prescription, subject to a $20 per month maximum for prescription drug co-payments. No co-payments shall apply to antipsychotic drugs when used for the treatment of mental illness; and

(5) 50 percent coinsurance on restorative dental services.

(e) Co-payments shall be limited to one per day per provider for nonpreventive visits, eyeglasses, and nonemergency visits to a hospital-based emergency room. Recipients of general assistance medical care are responsible for all co-payments in this subdivision. The general assistance medical care reimbursement to the provider shall be reduced by the amount of the co-payment, except that reimbursement for prescription drugs shall not be reduced once a recipient has reached the $20 per month maximum for prescription drug co-payments. The provider collects the co-payment from the recipient. Providers may not deny services to recipients who are unable to pay the co-payment, except as provided in paragraph (f).

(f) If it is the routine business practice of a provider to refuse service to an individual with uncollected debt, the provider may include uncollected co-payments under this section. A provider must give advance notice to a recipient

with uncollected debt before services can be denied.

(g) The co-payments described in paragraph (d) shall be waived by the provider if the recipient practices a healthy lifestyle by refraining from tobacco use or is participating in a smoking cessation program. To obtain the waiver, the recipient must sign a statement stating that the recipient does not use tobacco products or is currently participating in a smoking cessation program. The provider shall keep the signed statement on file.

~~(g)~~ (h) Any county may, from its own resources, provide medical payments for which state payments are not made.

~~(h)~~ (i) Chemical dependency services that are reimbursed under chapter 254B must not be reimbursed under general assistance medical care.

~~(i)~~ (j) The maximum payment for new vendors enrolled in the general assistance medical care program after the base year shall be determined from the average usual and customary charge of the same vendor type enrolled in the base year.

~~(j)~~ (k) The conditions of payment for services under this subdivision are the same as the conditions specified in rules adopted under chapter 256B governing the medical assistance program, unless otherwise provided by statute or rule.

~~(k)~~ (l) Inpatient and outpatient payments shall be reduced by five percent, effective July 1, 2003. This reduction is in addition to the five percent reduction effective July 1, 2003, and incorporated by reference in paragraph (i).

~~(l)~~ (m) Payments for all other health services except inpatient, outpatient, and pharmacy services shall be reduced by five percent, effective July 1, 2003.

~~(m)~~ (n) Payments to managed care plans shall be reduced by five percent for services provided on or after October 1, 2003.

~~(n)~~ (o) A hospital receiving a reduced payment as a result of this section may apply the unpaid balance toward satisfaction of the hospital's bad debts.

Sec. 26. Minnesota Statutes 2004, section 256L.07, subdivision 1, is amended to read:

Subdivision 1. [GENERAL REQUIREMENTS.] (a) Children enrolled in the original children's health plan as of September 30, 1992, children who enrolled in the MinnesotaCare program after September 30, 1992, pursuant to Laws 1992, chapter 549, article 4, section 17, and children who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines are eligible without meeting the requirements of subdivision 2 and the four-month requirement in subdivision 3, as long as they maintain continuous coverage in the MinnesotaCare program or medical assistance. Children who apply for MinnesotaCare on or after the implementation date of the employer-subsidized health coverage program as described in Laws 1998, chapter 407, article 5, section 45, who have family gross incomes that are equal to or less than 150 percent of the federal poverty guidelines, must meet the requirements of subdivision 2 to be eligible for MinnesotaCare.

(b) Families enrolled in MinnesotaCare under section 256L.04, subdivision 1, whose income increases above 275 percent of the federal poverty guidelines, are no longer eligible for the program and shall be disenrolled by the commissioner. Individuals enrolled in MinnesotaCare under section 256L.04, subdivision 7, whose income increases above 175 percent of the federal poverty guidelines are no longer eligible for the program and shall be disenrolled by the commissioner. For persons disenrolled under this subdivision, MinnesotaCare coverage terminates the last day of the calendar month following the month in which the commissioner determines that the income of a family or individual exceeds program income limits.

(c) ~~(1)~~ Notwithstanding paragraph (b), individuals and families ~~enrolled in MinnesotaCare under section 256L.04, subdivision 1,~~ may remain enrolled in MinnesotaCare if ten percent of their annual income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Individuals and families who are no longer eligible for MinnesotaCare under this subdivision shall be given ~~an 18-month~~ a 12-month notice period

from the date that ineligibility is determined before disenrollment. ~~This clause expires February 1, 2004.~~

~~(2) Effective February 1, 2004, notwithstanding paragraph (b), children may remain enrolled in MinnesotaCare if ten percent of their annual family income is less than the annual premium for a policy with a $500 deductible available through the Minnesota Comprehensive Health Association. Children who are no longer eligible for MinnesotaCare under this clause shall be given a 12 month notice period from the date that ineligibility is determined before disenrollment.~~ The premium for ~~children~~ individuals and families remaining eligible under this ~~clause~~ paragraph shall be the maximum premium determined under section 256L.15, subdivision 2, paragraph (b).

(d) Effective July 1, 2003, notwithstanding paragraphs (b) and (c), parents are no longer eligible for MinnesotaCare if gross household income exceeds $50,000.

Sec. 27. [256L.20] [MINNESOTACARE OPTION FOR SMALL EMPLOYERS.]

Subdivision 1. [DEFINITIONS.] (a) For the purpose of this section, the terms used have the meanings given them.

(b) "Dependent" means an unmarried child under 21 years of age.

(c) "Eligible employer" means a business that employs at least two, but not more than 50, eligible employees, the majority of whom are employed in the state, and includes a municipality that has 50 or fewer employees.

(d) "Eligible employee" means an employee who works at least 20 hours per week for an eligible employer. Eligible employee does not include an employee who works on a temporary or substitute basis or who does not work more than 26 weeks annually.

(e) "Maximum premium" has the meaning given under section 256L.15, subdivision 2, paragraph (b), clause (3).

(f) "Participating employer" means an eligible employer who meets the requirements described in subdivision 3 and applies to the commissioner to enroll its eligible employees and their

dependents in the MinnesotaCare program.

(g) "Program" means the MinnesotaCare program.

Subd. 2. [OPTION.] Eligible employees and their dependents may enroll in MinnesotaCare if the eligible employer meets the requirements of subdivision 3. The effective date of coverage is according to section 256L.05, subdivision 3.

Subd. 3. [EMPLOYER REQUIREMENTS.] The commissioner shall establish procedures for an eligible employer to apply for coverage through the program. In order to participate, an eligible employer must meet the following requirements:

(1) agrees to contribute toward the cost of the premium for the employee and the employee's dependents according to subdivision 4;

(2) certifies that at least 75 percent of its eligible employees who do not have other creditable health coverage are enrolled in the program;

(3) offers coverage to all eligible employees and the dependents of eligible employees; and

(4) has not provided employer-subsidized health coverage as an employee benefit during the previous 12 months, as defined in section 256L.07, subdivision 2, paragraph (c).

Subd. 4. [PREMIUMS.] (a) The premium for MinnesotaCare coverage provided under this section is equal to the maximum premium regardless of the income of the eligible employee.

(b) For eligible employees without dependents with income equal to or less than 175 percent of the federal poverty guidelines and for eligible employees with dependents with income equal to or less than 275 percent of the federal poverty guidelines, the participating employer shall pay 50 percent of the maximum premium for the eligible employee and any dependents, if applicable.

(c) For eligible employees without dependents with income over 175 percent of the federal poverty guidelines and for eligible employees with dependents with income over 275 percent of the federal poverty guidelines, the participating employer shall pay the full cost of the maximum premium for the eligible

employee and any dependents, if applicable. The participating employer may require the employee to pay a portion of the cost of the premium so long as the employer pays 50 percent of the cost. If the employer requires the employee to pay a portion of the premium, the employee shall pay the portion of the cost to the employer.

(d) The commissioner shall collect premium payments from participating employers for eligible employees and their dependents who are covered by the program as provided under this section. All premiums collected shall be deposited in the health care access fund.

Subd. 5. [COVERAGE.] The coverage offered to those enrolled in the program under this section must include all health services described under section 256L.03 and all co-payments and coinsurance requirements described under section 256L.03, subdivision 5, apply.

Subd. 6. [ENROLLMENT.] Upon payment of the premium, in accordance with this section and section 256L.06, eligible employees and their dependents shall be enrolled in MinnesotaCare. For purposes of enrollment under this section, income eligibility limits established under sections 256L.04 and 256L.07, subdivision 1, and asset limits established under section 256L.17 do not apply. The barriers established under section 256L.07, subdivision 2 or 3, do not apply to enrollees eligible under this section. The commissioner may require eligible employees to provide income verification to determine premiums.

Sec. 28. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective July 1, 2005, prior authorization is required for the diagnosis/treatment pairings described in subdivision 2 for reimbursement under Minnesota Statutes, chapters 256B, 256D, and 256L.

(b) This subdivision expires July 1, 2007, or when a list

is established according to Minnesota Statutes, section 256B.0625, subdivision 46, whichever is earlier.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) obstetrical ultrasound;

(2) positive emission tomography (PET) scans;

(3) electronic beam computed tomography (EBCT);

(4) virtual colonoscopy;

(5) spinal fusion, unless in an emergency situation related to trauma;

(6) bariatric surgery; and

(7) orthodontia.

Subd. 3. [SERVICES REQUIRING REVIEW BEFORE ADDITION TO PUBLIC PROGRAMS BENEFIT SETS.] No new medical device, brand drug, or medical procedure shall be included in the public programs benefit sets under Minnesota Statutes, chapter 256B, 256D, or 256L, until a technology assessment has been completed and the potential benefits are proven to outweigh the additional costs of the new device, drug, or procedure. Technology assessments by independent organizations with no conflict of interest should be used in making these determinations.

Sec. 29. [TASK FORCE ON CHILDHOOD OBESITY.]

(a) The commissioner of health, in consultation with the commissioners of human services and education, shall convene a task force to study and make recommendations on reducing the rate of obesity among the children in Minnesota. The task force shall determine the number of children who are currently obese and set a goal, including measurable outcomes for the state in terms of reducing the rate of childhood obesity. The task force shall make recommendations on how to achieve this goal, including, but not limited to, increasing physical activities; exploring opportunities to promote physical education and healthy eating programs; improving the nutritional offerings through breakfast and lunch menus; and evaluating the availability and choice of nutritional products offered in public schools. The members of the task force shall include

representatives of the Minnesota Medical Association; the Minnesota Nurses Association; the Local Public Health Association of Minnesota; the Minnesota Dietetic Association; the Minnesota School Food Service Association; the Minnesota Association of Health, Physical Education, Recreation, and Dance; the Minnesota School Boards Association; the Minnesota School Administrators Association; the Minnesota Secondary Principals Association; the vending industry; and consumers. The terms and compensation of the members of the task force shall be in accordance with Minnesota Statutes, section 15.059, subdivision 6.

(b) The commissioner must submit the recommendations of the task force to the legislature by January 15, 2007.

Sec. 30. [IMPLEMENTATION OF AN ELECTRONIC HEALTH RECORDS SYSTEM.]

The commissioner of health, in consultation with the electronic health record planning work group established in Laws 2004, chapter 288, article 7, section 7, shall develop a statewide plan for all hospitals and physician group practices to have in place an interoperable electronic health records system by January 1, 2015. In developing the plan, the commissioner shall consider:

(1) creating financial assistance to hospitals and providers for implementing or updating an electronic health records system, including, but not limited to, the establishment of grants, financial incentives, or low-interest loans;

(2) addressing specific needs and concerns of safety-net hospitals, community health clinics, and other health care providers who serve low-income patients in implementing an electronic records system within the hospital or practice; and

(3) providing assistance in the development of possible alliances or collaborations among providers.

The commissioner shall provide preliminary reports to the chairs of the senate and house committees with jurisdiction over health care policy and finance biennially beginning January 15, 2007, on the status of reaching the goal for all hospitals and

physician group practices to have an interoperable electronic health records system in place by January 1, 2005. The reports shall include recommendations on statutory language necessary to implement the plan, including possible financing options.

Sec. 31. [APPROPRIATION.]

(a) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the Board of Trustees of the Minnesota State Colleges and Universities for the nursing and health care education plan designed to:

(1) expand the system's enrollment in registered nursing education programs;

(2) support practical nursing programs in regions of high need;

(3) address the shortage of nursing faculty; and

(4) provide accessible learning opportunities to students through distance education and simulation experiences.

(b) $..... is appropriated for the biennium beginning July 1, 2005, from the general fund to the commissioner of health for the loan forgiveness program in Minnesota Statutes, section 144.1501."

Delete the title and insert:

"A bill for an act relating to health care; modifying premium rate restrictions; establishing expenditure limits; modifying cost containment provisions; modifying certain loan forgiveness programs; modifying medical assistance, general assistance medical care, and MinnesotaCare programs; requiring reports; appropriating money; amending Minnesota Statutes 2004, sections 62A.65, subdivision 3; 62D.12, subdivision 19; 62J.04, subdivision 3, by adding a subdivision; 62J.041; 62J.301, subdivision 3; 62J.38; 62J.692, subdivision 3; 62L.08, subdivision 8; 144.1501, subdivisions 2, 4; 256.045, subdivision 3a; 256.9693; 256B.0625, subdivision 3b, by adding a subdivision; 256B.0627, subdivisions 1, 4, 9; 256B.0631, by adding a subdivision; 256D.03, subdivision 4; 256L.07, subdivision 1; proposing coding for new law in Minnesota Statutes, chapters 62J; 62Q; 256; 256B; 256L."

Take care of your health.

Introducing savings for qualified individuals and families without prescription drug coverage.

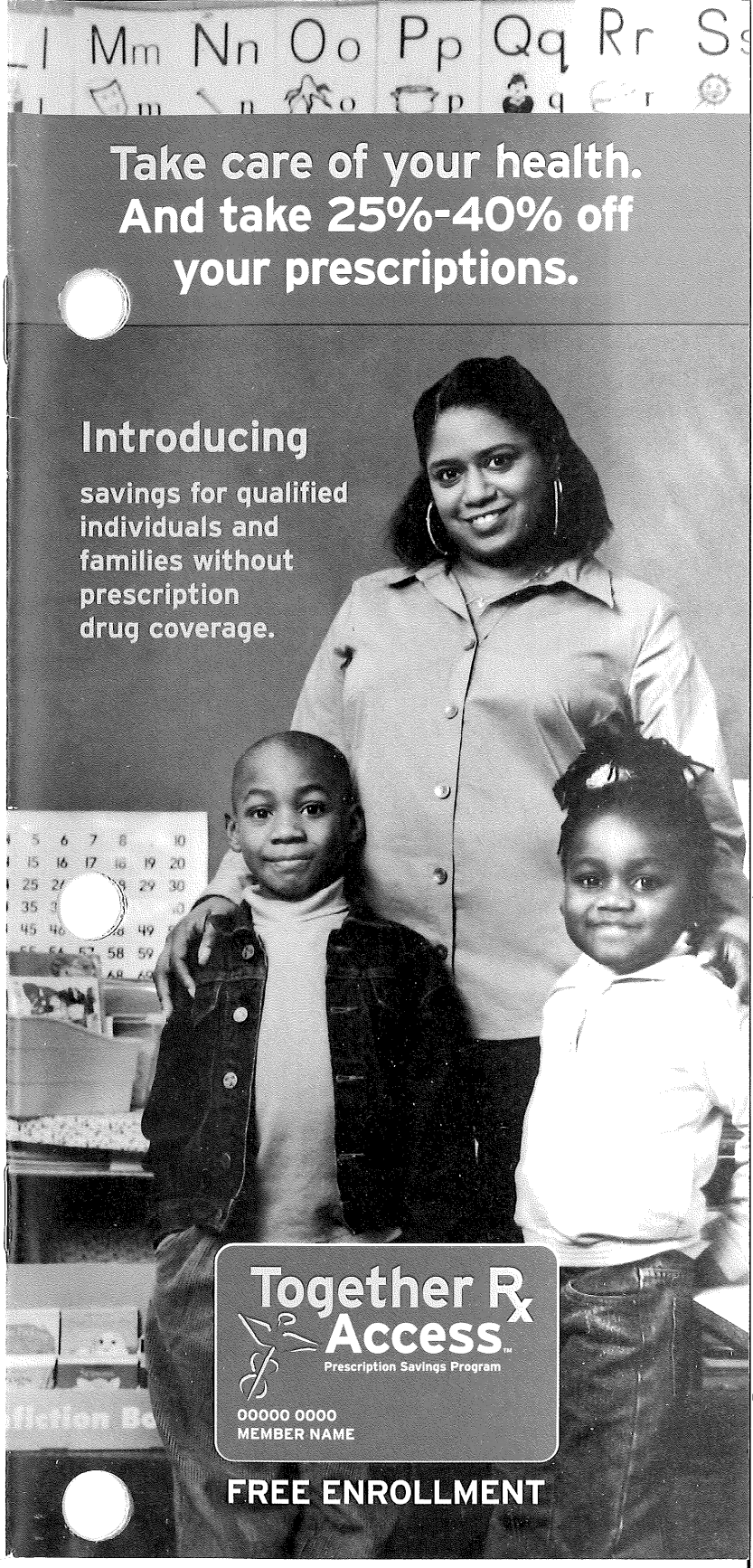
The FREE Together Rx Access Card gives you:

- Savings of approximately 25%-40% and sometimes more* on your medicines.
- FREE savings on over 275 brand-name prescription drugs and other prescription products, as well as a wide range of generic drugs – right at the pharmacy counter.
- Access to products made by many of the world's best known pharmaceutical companies.

Enrolling is easy.

- Complete the enrollment form inside to start saving.
- To learn more or to ask questions, call us at 1-800-444-4106.
- You may also apply online at www.TogetherRxAccess.com.

* Savings may vary depending on the pharmacy's customary pricing for each specific product and the savings program offered by the participating company that makes it. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.



Better access.

Save 25%-40% and sometimes more on prescription medicines.

With the FREE Together Rx Access™ Card, you save approximately 25%-40% and sometimes more* on over 275 brand-name prescription drugs and other prescription products, as well as a wide range of generic drugs. There are no enrollment fees, no monthly fees, and no hidden charges. To see if your medicine is covered, please see the list at the back of this brochure.

Instant savings right at the pharmacy counter.

Apply for the card using the enrollment form included in this brochure. Once you receive your Together Rx Access Card, simply bring it to a participating pharmacy with your prescription, and your pharmacist will calculate your savings. It's that easy – and the majority of pharmacies accept the card.

Sponsored by major pharmaceutical companies.

Together Rx Access helps you take care of what's most important – your health. And some of the world's largest pharmaceutical companies are making it possible.

For more information, call 1-800-444-4106, or visit www.TogetherRxAccess.com.

* Savings may vary depending on the pharmacy's customary pricing for each specific product and the savings program offered by the participating company that makes it. Participating companies independently set the level of savings offered and the products included in the program. Those decisions are subject to change.

To more medicines.

ABBOTT LABORATORIES

AstraZeneca

Bristol-Myers Squibb Company

gsk GlaxoSmithKline

JANSSEN PHARMACEUTICA PRODUCTS, L.P.

NOVARTIS

ORTHO-McNEIL PHARMACEUTICAL, INC.

Pfizer

sanofi aventis
Because health matters

Takeda

TAP

Getting started on your savings.

Are you eligible?

Finding out if you're eligible for Together Rx Access is easy. If you can check all of the boxes below, then you are eligible:

☐ Not eligible for Medicare

☐ No prescription drug coverage (public or private)

☐ Household income* equal to or less than

- $30,000 for a single person
- $40,000 for a family of two
- $50,000 for a family of three
- $60,000 for a family of four
- $70,000 for a family of five

For families of six or more, contact Together Rx Access at **1-800-444-4106** to determine eligibility.

☐ Legal US resident

How do you apply?

For your convenience, an enrollment form is included in this brochure. It's easy and takes just a few minutes to complete.

For more information, call **1-800-444-4106**, or visit **www.TogetherRxAccess.com.**

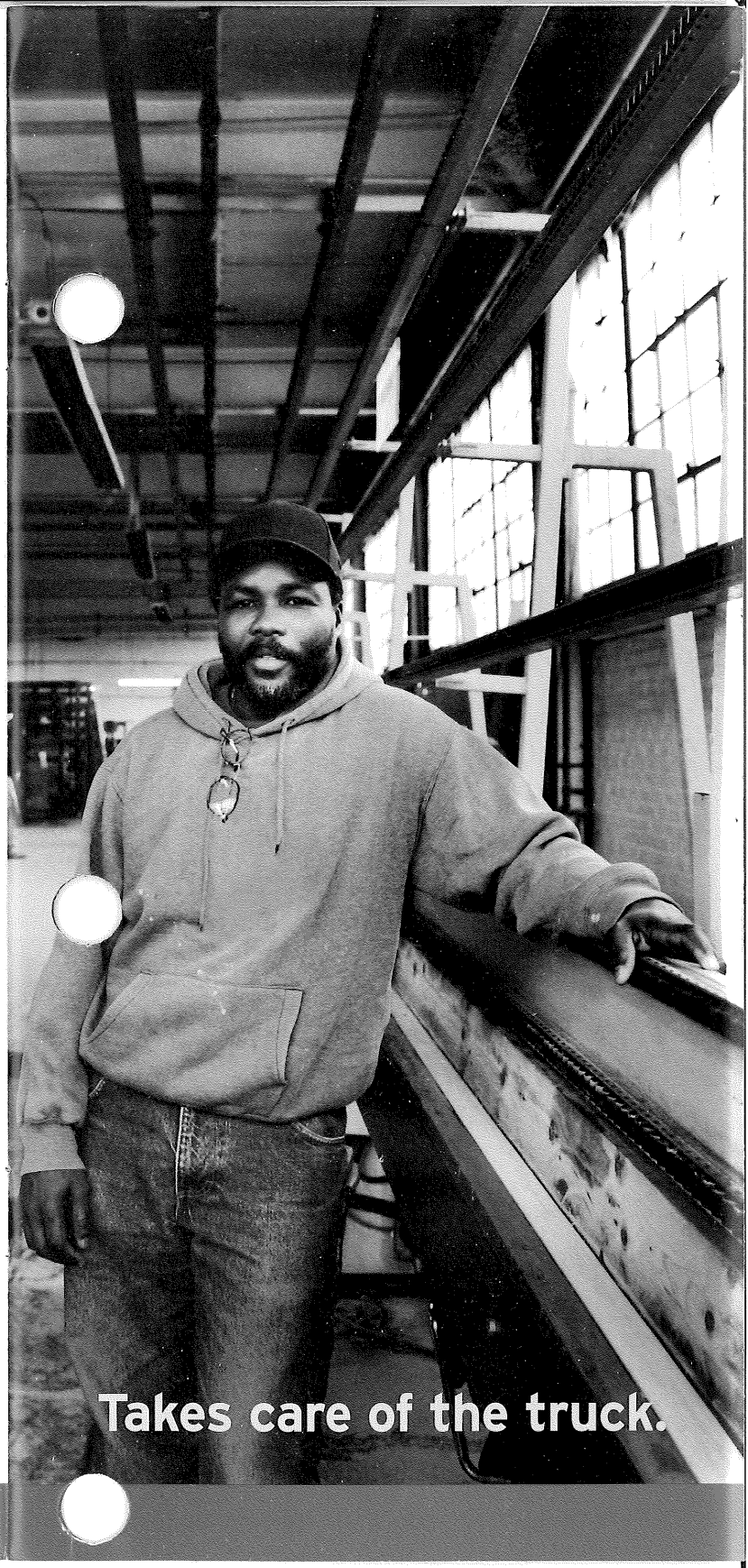
* Income limits may be higher in Alaska and Hawaii.

Savings on prescriptions. With no strings attached.

When you apply for the Together Rx Access Card, you can rest assured there are no enrollment fees, no monthly fees, and no hidden fees. Your privacy is important to us. Information that identifies you will not be shared with companies outside the program. Together Rx Access is simply about real savings from some of the world's largest pharmaceutical companies.

Have questions?

If you have questions about Together Rx Access, please call **1-800-444-4106** or visit **www.TogetherRxAccess.com.**



Start saving. Enroll today.

Applying is simple.

Just complete and mail (no postage necessary) the simple enrollment form on the next page to start saving on your prescription medicines with Together Rx Access. Applying is free, and there are no hidden fees.

Your privacy is important to us. Information that identifies you will not be shared with companies outside the program.

For questions about enrolling, or to get additional enrollment forms, call 1-800-444-4106.

You may also apply online at **www.TogetherRxAccess.com.**

Together Rx Access™
Prescription Savings Program
00000 0000
MEMBER NAME

Apply today – by mail or online at www.TogetherRxAccess.com.

LINE

ADDITIONAL DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a dependent who meets these criteria, please list below.

DEPENDENTS (WHO MEET ELIGIBILITY REQUIREMENTS):

FOLD

YES, I'd like to be considered for the Together Rx Access™ Card. I understand that the card is absolutely FREE.

1. REMOVE the enrollment form by tearing along the dotted line below.
2. Remove the blank strip on each side of the form.
3. THEN FILL OUT the form – ONE per family. All fields must be completed to be considered for the Together Rx Access Card. Information to be completed by applicant or legal representative. Review the Program Information on the back of the application form. **Please note: You must use a blue or black ink pen. DO NOT attach any other information.**
4. Check to make sure you have completed the enrollment form. If you have any questions, call 1-800-444-4106.
5. SEPARATE the envelope from the form by tearing along the dotted line.
6. Fold the form, and slide it inside the envelope. Then moisten the adhesive flap, fold, and seal.
7. Drop your Together Rx Access enrollment form in the mail. No postage is necessary.

Together Rx Access™ Prescription Savings Program
00000 0000
MEMBER NAME

You may also enroll online
www.TogetherRxAccess.c

FOLD AND TEAR ALONG DOTTED LINE

FOLD AND TEAR ALONG DOTTED LINE

Together Rx Access™ Prescription Savings Program
00000 0000
MEMBER NAME

ENROLLMENT FORM

You may also enroll online at **www.TogetherRxAccess.com**

YOUR INFORMATION

First Name M.I. Last Name

Address (Street Number / Street Name / Apartment Number)

City State Zip Code

- - - - - -

Telephone Date of Birth (mm/dd/yyyy) Social Security Number

Gender: ☐ M ☐ F Race: (Optional) ☐ Caucasian ☐ Black ☐ Asian ☐ Hispanic ☐ Other

Are you a legal US resident? Yes ☐ No ☐

Are you eligible for Medicare? Yes ☐ No ☐

Do you have prescription drug coverage of any kind (public/private)? Yes ☐ No ☐

HOUSEHOLD ANNUAL INCOME: Please provide your annual (12 months) gross income from your last Federal Income Tax Return. If you did not file a tax return due to minimum filing requirements, please estimate your household income. Note: If you are married and reside with your spouse, you must include both incomes regardless of tax filing status. $,

SPOUSE OR DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a spouse and/or dependent who meets these criteria, please list below. (To enroll more than 4 dependents, please use the space on the back of this form.)

SPOUSE (IF ELIGIBLE):

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

DEPENDENTS (WHO MEET ABOVE ELIGIBILITY REQUIREMENTS):

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

First Name M.I. Last Name Gender: ☐ M ☐ F Date of Birth (mm/dd/yyyy) - -

FOLD AND TEAR ALONG DOTTED LINE

MAY WE CONTACT YOU?

By checking YES, you agree that Together Rx Access and its business partners may contact you about new programs and services, additional product and health information, or for market research purposes. Yes ☐ No ☐

I have read, understand, and accept the Program Information including the limitations and authorization to use and disclose information sections on the back of this form. I certify that the information on this enrollment form is accurate and complete. I understand and agree that an Administrator of the Together Rx Access program may contact me in the future to verify this information.

Signature of Applicant or Representative **Signature of Spouse** (if applicable) Today's Date (mm/dd/yyyy) - -

TAC-EN1204

NO POSTAGE NECESSARY IF MAILED IN THE UNITED STATES

BUSINESS REPLY MAIL

FIRST-CLASS MAIL PERMIT NO. 59049 WILMINGTON, DE

POSTAGE WILL BE PAID BY ADDRESSEE

TOGETHER RX ACCESS LLC
PO BOX 9426
WILMINGTON DE 19809-9944

FOLD AND TEAR ALONG DOTTED LINE

PROGRAM INFORMATION

ENROLLMENT
I understand that Together Rx Access has hired an Administrator to administer the Together Rx Access program, who will review my enrollment form, determine my eligibility, and notify me based on the information I provide. The Administrator may at any time require additional information to determine or confirm my eligibility. If I am eligible, I will receive a membership packet and Card by mail.

LIMITATIONS
Savings under the Program do not apply to prescription products reimbursed under any federal or state program, including Medicare or Medicaid ("Government Program"), or any private insurance, HMO, Medigap, employer, or other third-party arrangement ("Private Insurance"). By signing the enrollment form, I certify that I am not, nor are any of my family members listed on this application, eligible for Medicare, and I do not have prescription drug coverage through any government program or private insurance, nor do any of my family members listed on this application.

The Card may be used only for outpatient prescription products included in the Program. Participating companies independently determine which products to include and the savings offered. Products and savings may change at any time.

The Card may not be used with other prescription discount cards or pharmacy coupons. Coupons redeemed directly by a participating company are subject to the terms and conditions of the coupon.

The Card is valid only in the US and Puerto Rico. The Program may be terminated or modified at any time.

AUTHORIZATION TO USE AND DISCLOSE INFORMATION
I understand that Together Rx Access and the Administrator will receive information about me and the prescription products that I receive using the Card. By signing this application, I authorize Together Rx Access and the Administrator to:

- use that information to administer the Program and to communicate with me, and
- share that information with participating companies for market research or analysis.

This authorization is in addition to any authorization that I have given under the heading "May We Contact You?" on the reverse side of this application. Together Rx Access does not provide/sell information that identifies you to third party companies not associated with the Program.

I may revoke this authorization by ending my participation in the Program by writing to Together Rx Access at the address provided in my membership packet.

FOLD AND TEAR ALONG DOTTED LINE

ADDITIONAL DEPENDENTS: You may enroll additional family members in the Together Rx Access Program if: 1) you can claim them as a financial dependent on tax returns or other government programs; 2) they are not eligible for Medicare; 3) they do not have prescription drug coverage; and 4) they are a legal US resident. If you have a dependent who meets these criteria, please list below.

DEPENDENTS (WHO MEET ELIGIBILITY REQUIREMENTS):

First Name	M.I.	Last Name	Gender: M F	Date of Birth (mm/dd/yyyy)
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -
			☐ ☐	- -

Before mailing, did you remember to:

☐ Complete the entire form?

☐ Sign the bottom of the form?

☐ Enclose the form in this envelope?

Look for your Together Rx Access Card in the mail soon!

Save on these brand-name prescription medicines with Together Rx Access.™

List of medicines as of January 1, 2005.
For the most current list of medicines and products, visit www.TogetherRxAccess.com.

Abilify®*
(aripiprazole)

Accolate® Tablets
(zafirlukast)

Accupril®
(quinapril HCl)

Accuretic™
(quinapril HCl/hydrochlorothiazide)

Actos®
(pioglitazone hydrochloride tablets)

Advair Diskus®
(fluticasone propionate and salmeterol inhalation powder)

Agenerase®
(amprenavir)

Alamast®
(pemirolast potassium ophthalmic solution)

Albenza®
(albendazole)

[illegible]tazide®
[illegible]lactone and hydrochloralhiazide)

Aldactone®
(spironolactone)

Allegra® 18omg, 6omg, and 3omg
(fexofenadine HCl)

Allegra D®
(fexofenadine HCl/pseudophedrine hydrochloride)

Amaryl®
(glimepiride)

Ambien®
(zolpidem)

Amerge®
(naratriptan hydrochloride)

Amoxil®
(amoxicillin)

Ansaid®
(flurbiprofen)

Antivert®
([illegible]ine HCl)

Anzemet®
(dolasetron mesylate injection/tablets)

Arava®
(leflunomide)

Arimidex® Tablets
(anastrozole)

Arixtra®
(fondaparinux sodium)

Arthrotec®
(diclofenac sodium and misoprostol)

Atacand HCT® Tablets
(candesartan cilexetil-hydrochlorothiazide)

Atacand® Tablets
(candesartan cilexetil)

Augmentin®
(amoxicillin/clavulanate potassium)

Augmentin ES®
(amoxicillin/clavulanate potassium)

Augmentin XR®
(amoxicillin/clavulanate potassium)

Avalide®
(irbesartan-hydrochlorothiazide)

Avandamet™
(rosiglitazone maleate/metformin HCl)

Avandia®
(rosiglitazone maleate)

Avapro®*
(irbesartan)

Avodart™
(dutasteride)

Axert®
(almotriptan malate)

Azulfidine®
(sulfasalazine, enteric coated)

Bactroban®
(mupirocin calcium, 2%)

Beconase®
(beclomethasone dipropionate)

Betimol®
(timolol ophthalmic solution)

Bextra®
(valdecoxib)

Biaxin® XL
(clarithromycin extended-release tablets)

Biaxin® XL Pac
(clarithromycin extended-release tablets)

Bicitra®
(sodium citrate & citric acid)

Caduet®
(amlodipine besylate/atorvastatin calcium)

Calan®
(verapamil hydrochloride)

Calan SR®
(verapamil hydrochloride)

Cardura®
(doxazosin mesylate)

Casodex® Tablets
(bicalutamide)

Caverject®
(alprostadil for injection)

Ceftin®
(cefuroxime axetil)

Cefzil®
(cefprozil)

Celebrex®
(celecoxib)

Celontin®
(methsuximide)

Centany™
(mupirocin ointment)

Cleocin HCl®
(clindamycin hydrochloride)

Cleocin Pediatric Oral Susp®
(clindamycin palmitate hydrochloride)

Cleocin T®
(clindamycin phosphate)

Cleocin Vaginal Cream/Ovules®
(clindamycin phosphate)

Clozaril®
(clozapine)

Colestid®
(colestipol hydrochloride)

CombiPatch™
(estradiol/norethindrone acetate transdermal system)

Combivir®
(lamivudine/zidovudine)

Comtan®
(entacapone)

Concerta®
(methylphenidate HCl)

Coreg®
(carvedilol)

Cortef®
(hydrocortisone)

Coumadin®
(warfarin sodium)

Covera-HS®
(verapamil hydrochloride extended-release)

Crestor® Tablets
(rosuvastatin calcium)

Cytotec®
(misoprostol)

Daraprim®
(pyrimethamine)

Daypro®
(oxaprozin)

Demulen ethynodiol®
(diacetate, ethinyl estradiol)

Depakote®
(divalproex sodium delayed-release tablets)

Depakote® ER
(divalproex sodium extended-release tablets)

Depakote® Sprinkle Caps
(divalproex sodium coated particles in capsules)

Depo-Estradiol®
(estradiol cypionate)

Depo-Medrol®
(sterile methylprednisolone acetate)

Depo-Provera®
(medroxyprogesterone acetate)

Detrol®
(tolterodine tartrate)

Detrol® LA
(tolterodine tartrate extended release)

Dexedrine®
(dextroamphetamine sulfate)

DiaBeta®
(glyburide USP)

Diabinese®
(chlorpropamide)

Diflucan®
(fluconazole)

Dilantin®
(phenytoin)

Diovan®
(valsartan)

Diovan HCT®
(valsartan and hydrochlorothiazide)

Ditropan®
(oxybutynin chloride)

Ditropan® Syrup
(oxybutynin chloride)

Ditropan XL®
(oxybutynin chloride)

Dostinex®
(cabergoline)

Duragesic®
(fentanyl transdermal system)

Dyazide®
(hydrochlorothiazide/triamterene)

Elidel®
(pimecrolimus)

Elmiron®
(pentosan polysulfate sodium)

Epivir®
(lamivudine)

Epivir-HBV®
(lamivudine)

Epzicom™
(abacavir sulfate and lamivudine)

Ertaczo™
(sertaconazole nitrate)

Eskalith®
(lithium carbonate)

Eskalith CR®
(lithium carbonate)

Estraderm®
(estradiol transdermal system)

Estring®
(estradiol vaginal ring)

Exelon®
(rivastigmine tartrate)

Famvir®
(famciclovir)

Feldene®
(piroxicam)

Femara®
(letrozole tablets)

Flagyl®
(metronidazole)

Flexeril®
(cyclobenzaprine HCl)

Flonase®
(fluticasone propionate)

Flovent®
(fluticasone propionate)

Floxin®
(ofloxacin)

Focalin™
(dexmethylphenidate hydrochloride)

Fragmin®
(dalteparin sodium)

Geocillin®
(carbenicillin indanyl sodium)

Geodon®
(ziprasidone HCl)

Glucotrol®
(glipizide)

Glucotrol XL®
(glipizide extended release)

Glynase®
(micronized glyburide)

Glyset®
(miglitol)

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(griseofulvin tablets)

Grifulvin-V® Susp
(griseofulvin)

Haldol® Dec
(haloperidol decanoate)

Imitrex®
(sumatriptan succinate)

Inspra®
(eplerenone)

Ketek®
(telithromycin)

Lamictal®
(lamotrigine)

Lamisil®
(terbinafine HCl tablets)

Lanoxicaps®
(digoxin solution in capsules)

Lanoxin®
(digoxin)

Lantus®
(insulin glargine)

Lasix®
(furosemide)

Lescol®/Lescol® XL
(fluvastatin sodium)

Leukeran®
(chlorambucil)

Levaquin®*
(levofloxacin)

Lexiva®
(fosamprenavir calcium)

Lincocin®
(lincomycin hydrochloride)

Lipitor®
(atorvastatin calcium)

Loniten®
(minoxidil)

Lopid®
(gemfibrozil)

Lotrel®
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Malarone®
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Aventis Pasteur
Aventis Pasteur Indigent Patient Program/NORD
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MCSP Patient Assistance Program
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ACT (Accessing Coverage Today) for EMEND
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Millennium Pharmaceuticals, Inc.
Integrilin Patient Assistance Program | P 1-800-232-8723

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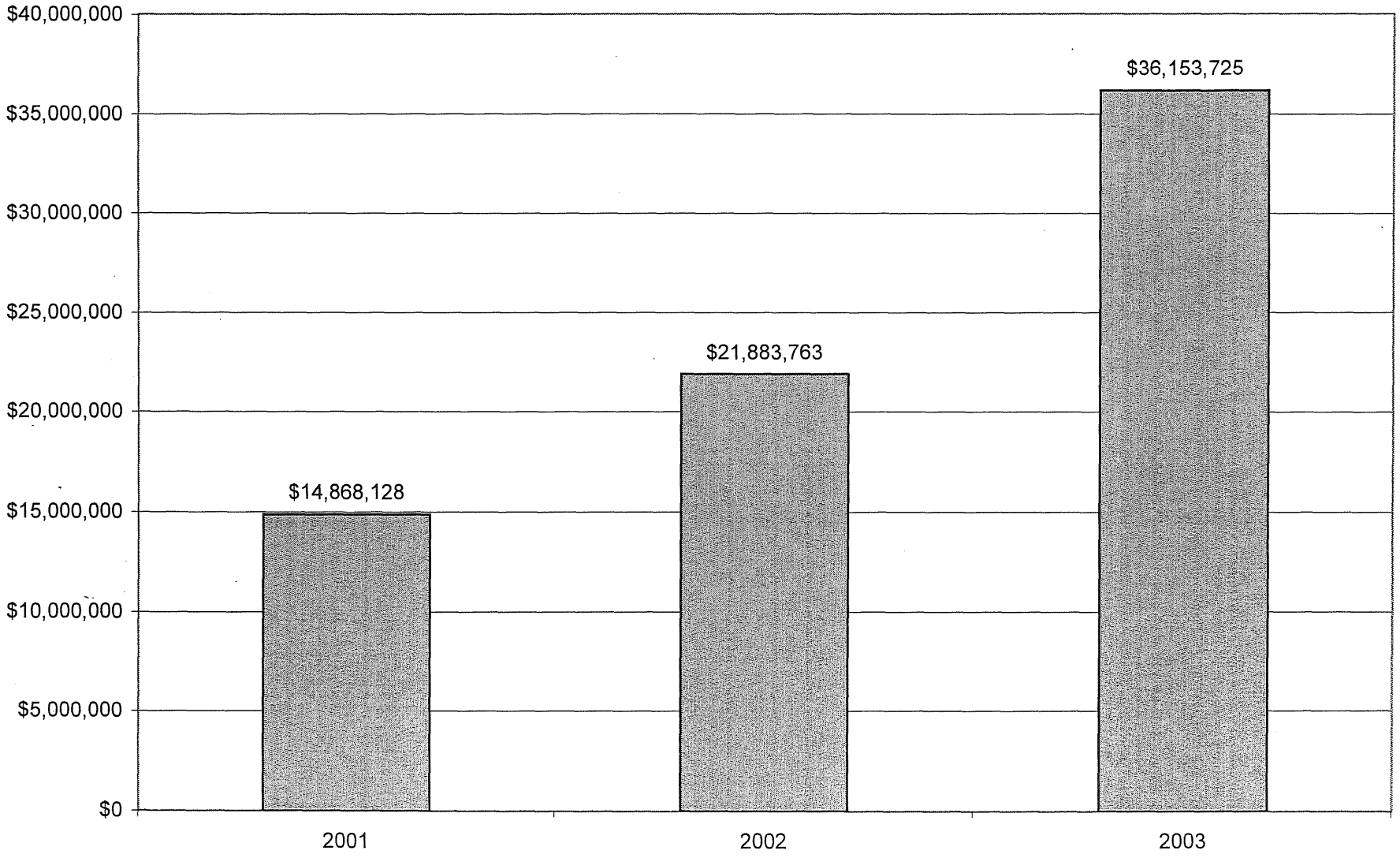

*Data are from six MN managed care organizations.

Sen. Berglin

Testimony on behalf of the Minnesota Universal Health Care Coalition regarding Best Practices and Quality Improvement, as set forth in Section 8 of SF 65
Prepared by Kip Sullivan

Introduction

For over 30 years, influential groups and individuals have demanded that someone publish grades on the quality of care offered by physicians, hospitals and health plans. Advocates of managed care and managed competition have been the most prominent proponents of "report cards," as published performance-measurement reports came to be called by approximately 1993. Dr. Paul Ellwood, the former Minnesota physician who coined the phrase "health maintenance organization," has been demanding report cards on physicians and plans for three decades.[1,2,3] Leading advocates of managed competition, including former President Bill Clinton and the Jackson Hole Group, viewed report cards as an essential feature of a managed competition system.[4,5]

But despite all the pressure for report cards from politicians, employers, and experts in academia and think tanks, not a single accurate *plan* report card has been published anywhere in the country, and accurate physician, clinic, and hospital report cards are almost nonexistent. The report card on heart surgeons published annually by the New York Department of Health may be the only regularly published report card that can be reasonably characterized as accurate. Virtually all other report cards touted by health insurance companies, government agencies, business coalitions, business consultants, magazines, and Internet entrepreneurs either do not attempt to measure quality directly (for example, they report whether a doctor is board-certified, whether a hospital is highly regarded by physicians, or whether patients of undetermined health status are "satisfied" with a plan or clinic), or they measure quality directly but with significant inaccuracy.[6]

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[1] Paul M. Ellwood, Jr, et al. "Health maintenance strategy," *Medical Care* 1971;9:291-98.

[2] Paul M. Ellwood, "A technology of patient experience," *New England Journal of Medicine* 1988;318:1549-56.

[3] Paul M. Ellwood, Jr. and George D. Lundberg, "Managed care: A work in progress," *JAMA* 1996;276:1083-86.

[4] Arnold M. Epstein, "Changes in the delivery of care under comprehensive health care reform," *New Engl J Med* 1993;329:1672-76.

[5] Paul M. Ellwood, Alain C. Enthoven, and Lynn Etheridge, "The Jackson Hole initiatives for a Twenty-First Century American health care system," *Health Econ* 1992;1:149-68.

[6] Here are three statements by experts to the effect that accurate report cards are virtually nonexistent:

> "[P]hysician profiles are not and may never be ready for public consumption" (Andrew Bindman, "Can physician profiles be trusted"? *JAMA* 1999;281: 2142-2143, 2143).

> "Despite 15 years of concerted effort, performance measures have not been adopted system-wide to improve quality in the US health care system" (Robert S. Galvin and Elizabeth A. McGlynn, "Using performance measurement to drive improvement: A road map for change," *Medical Care* 2003;41:I-48-I-60).

> "Hospital profiling remains an unproven strategy for improving outcomes of care for medical conditions" (David W. Baker et al., "Mortality trends during a program that publicly reported hospital performance," *Medical Care* 2002;40:879-890, 879).

Despite the abysmal track record of the report card movement, and despite the daunting obstacles facing those who seek to publish accurate report cards, the demand for report cards among Minnesota's political and business leaders reached new heights in 2004. In May 2004, the Legislature enacted a bill authorizing the Department of Health to identify "best practice guidelines" and to facilitate the production of report cards measuring how well physicians comply with these guidelines. The new law (*Minnesota Statutes* 62J.43) also authorizes the Department of Employee Relations (DOER) to use report cards in making decisions about which plans to make available to state employees, and the Department of Human Services (DHS) to use report cards in deciding which plans low-income Minnesotans will be allowed to enroll in.[7] Last November, the Minnesota Council of Health Plans posted a report card on a Web site (www.mnhealthcare. org) which allegedly measures quality of care for diabetes, asthma and several other diseases at the "medical group" level. In that same month, Governor Pawlenty announced the formation of the Smart Buy Alliance which the governor claims will prepare report cards on numerous medical services and use them to steer patients to plans and providers with superior grades.[8]

In January 2005, several senators introduced SF 65 which includes language requiring the state to use its clout as a purchaser of health insurance to force plans to punish providers who score poorly on report cards. Whereas current law (62J.43) says DHS and DOER *may* use report cards "to make decisions about contracts they enter into with health plan companies," SF 65 *requires* such use of report cards. Whereas current law does not authorize DHS and DOER to use financial incentives to force plans to impose guidelines on doctors, SF 65 says DHS and DOER "*shall* establish payment withholds based on best practices and quality of care measurements" by 2007 (emphasis added). SF 65 states moreover that plans may punish a provider who "fails to follow the best practices and quality of care measurement criteria identified" in Section 62J.43.

All three of these actors – the Legislature, the Governor, and the Council of Health Plans – claim that public reporting of quality measures will not only improve quality but will also reduce health care costs. Section 62J.43 begins with the words, "To improve quality and reduce health care costs." In announcing the Smart Buy Alliance, Governor Pawlenty stated, "[R]ewarding providers for improved health outcomes and encouraging patients to use the best providers will not only help contain costs, it will improve the quality of care."[9] The Governor's press release specifically cited the Council of Health Plans' recently released report card as an

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[7] Section 62J.43 does not define a "best practice guideline," and it is vague about who is supposed to write them, who is supposed to measure physician compliance with them, and what standards if any the people measuring physician compliance must follow. As we read the statute, it seems to say the Department of Health (MDH) will develop (although it is not clear that's the right verb) "best practice guidelines" in consultation with a non-profit entity (which everyone understood would be the Institute for Clinical Systems Improvement). The Department of Human Services and the Department of Employee Relations were given the option of using report cards based on these guidelines in deciding which plans to contract with. We cannot divine from Section 62J.43 how report cards, as opposed to guidelines, are to be produced and who is to produce them. The statute refers to "information available to the commissioner on adherence to best practices care by physicians," but it does not say how that information is supposed to come into existence nor does it set any standards by which this "information" must be developed to insure its accuracy. Section 62J.43 seems to require MDH (again the statute speaks in the passive voice) to develop "best practices and quality of care measurement criteria" first on asthma, diabetes, "at least two other preventive health measures," hypertension, and coronary artery disease.

[8] Patricia Lopez, "Pawlenty tackles health care," *Star Tribune*, November 30, 2004, A1.

[9] "Governor Pawlenty unveils 'Smart Buy' Alliance to slow health care costs and improve quality," press release, November 29, 2004, http://www.governor.state.mn.us, accessed November 30, 2004.

example of a document the Smart Buy Alliance will use to punish allegedly inferior providers. But these initiatives will probably, at best, have little impact on quality and, therefore, on cost, and could, at worst, damage quality for many patients.

MUHCC supports the use of evidence-based medical guidelines by doctors. The coalition is opposed, however, to the requirement that someone develop "quality of care measurements," as 62J calls report cards, and that DHS and DOER use those measurements, *regardless of their accuracy*, to punish plans and providers that do not score well. As I shall demonstrate in a moment, report cards,[10] even fairly accurate report cards, can harm patients. To minimize risk to patients, we recommend that 62J.43 be amended to require that report cards be accurate and to establish a process for determining whether report cards are accurate. We recommend, moreover, that the Legislature reject the provisions in SF 65 that require state agencies to use report cards on a wholesale basis, and amend 62J.43 to require DHS, DOER or the Department of Health to engage only in a limited pilot project to test whether report cards can be accurate and can improve quality of care for at least some patients without harming quality for others. In short, we urge you to treat report cards the way the FDA treats new drugs: Report cards should be assumed to be ineffective and/or to pose an unacceptable risk to patients until proven otherwise.

Review of assumptions underlying report cards

Those who claim report cards improve quality and reduce cost rely on four unproven assumptions:

(1) quality of all or most medical services can be measured so accurately that state agencies and plans should feel free to use their muscle to punish providers that score poorly, and the public should be encouraged to punish low-scoring plans and providers by abandoning them in favor of allegedly superior plans and providers;
(2) punishing low-scoring providers will always or most of the time cause improvements in quality, and never or rarely cause declines in quality;
(3) improvements in quality lead always or most of the time to reduced costs, never or rarely to higher costs; and
(4) the savings to be achieved by the improvement in quality, allegedly induced by report cards, will be so great as to swamp the cost of producing and distributing report cards.

The facts contradict these assumptions. The evidence supports the following conclusions:

(1) measuring quality of care accurately is usually very difficult and very expensive;
(2) using report cards to punish doctors, either by embarrassing them publicly or by punishing them financially, probably has a net effect of damaging patients;
(3) some improvements in quality lead to higher costs; and

[10] I use "report card" to mean any document that purports to evaluate the quality of health care offered by a provider or plan that is published or, if it is not published, is used by purchasers to make decisions about which plans and providers to contract with, or by plans to decide which providers to contract with. Thus, a document purporting to measure quality of providers or plans that is merely shared privately with the providers or plans is not a report card.

(4) the savings from quality improvements are often swamped by the cost of bringing about the quality improvement.

I will not attempt to address all of these assumptions in this testimony. I will focus on the second assumption, the assumption that report cards are a safe and effective method of improving quality.

Report cards can damage patients three ways: (1) by being inaccurate and thereby steering patients from superior to inferior providers; (2) by inducing doctors to refuse to treat sicker patients because they fear the report cards do not adjust their grades sufficiently to reflect the difficulty of treating the very sick; and (3) by inducing providers and plans to shift resources away from patients receiving ungraded care to patients receiving graded care.

Report cards can damage quality of care by being inaccurate

Measuring quality of care is difficult because it is difficult to measure only factors within physician control. If we were going to measure the quality of auto mechanics in St. Cloud, to take a simple example, we would want to make sure that we were measuring only differences in mechanic skills, not differences in the age of the cars being repaired nor differences in the incomes and behavior of car owners. The same logic applies to measuring quality of medical care: We want to measure differences in physician skill, not differences in patients' health, literacy, income, or health insurance, to name the more important variables beyond physician control.

For example, if we want to compare quality of care offered to diabetics, and our measure of quality is percent of diabetics with their cholesterol under control, we must adjust the scores to reflect differences between clinics' patients on a number of variables, including the ability of patients to buy statins (the drugs doctors usually prescribe to reduce cholesterol). Clinic A may have the best doctors in the world, but if that clinic sees an above-average number of diabetics who have no health insurance (or health insurance with no drug coverage or drug coverage with big co-payments), Clinic A's score will be below average for reasons that have nothing to do with quality of care offered by Clinic A.

The process of adjusting for factors outside of physician control is known as "risk adjustment" (and, less commonly, as "case-mix adjustment"). There is a consensus among experts who publish in medical and health policy journals that risk adjustment is essential to any attempt to compare the quality of care offered by providers (see Appendix A).

Evidence indicates that factors outside of physician control have much more influence on many conventional quality measures than physician skill. In its October 2004 newsletter for physicians, PreferredOne reported that only 16 percent of patients enrolled in PreferredOne's HMO diagnosed with high blood pressure "were compliant in getting their medications refilled."[11] The newsletter did not attempt to explain why 84 percent were out of compliance, but we may state with some confidence that poor quality care by these patients' doctors was not a major factor and was possibly no factor at all. The doctors had diagnosed their patients' hypertension, and they had prescribed appropriate medication for them. Obviously we must look to factors outside of physician control – such as the cost of medications, copayments for medications, lack of coverage for drugs, drug side effects, and the ineffectiveness of

[11] "Hypertension and medication compliance," *PreferredOne Update*, October 2004, 7.

hypertension drugs for some patients – to explain an 84 percent rate of noncompliance.[12] It is at best very misleading, and at worst just plain false, to say that this low compliance rate is evidence of poor "quality of care" by either PreferredOne or its doctors. That would be like saying an auto mechanic shop is providing poor quality service because 84 percent of its customers can't or won't bring their cars in for regular maintenance.

Research indicates that when many conventionally used quality measures are rigorously risk-adjusted, factors outside physician control turn out to be far more influential than differences within physician control. Silver and Rosenbaum concluded, "We found that patient characteristics were 315 times more important than hospital characteristics in predicting mortality after simple surgery, so small errors in risk adjustment may loom large compared to hospital differences."[13] Hofer et al. report that "most of the published evidence suggests that ... individual physicians rarely account for more than 4 percent of the variation in common profile measures after case-mix adjustment," and that the physician effect (often referred to as the "practice style" effect) explained just 3 percent of the variation among physicians in blood sugar control among diabetics.[14]

As you might surmise from these examples, risk-adjustment – accounting for factors outside physician control such as patient health, income, and insurance status – is difficult and expensive. That is why virtually all report cards that have been produced to date have been inaccurate. This is true of report cards produced by large employer groups (such as Buyers Health Care Action Group here in Minnesota), by government agencies (such as the hospital mortality report produced by the federal government in the late 1980s, and the "You and Your Health Plan" report card produced by the now defunct Minnesota Health Data Institute in 1995), and the report card on "medical groups" published last November by the Minnesota Council of Health Plans (MCHP). Because Governor Pawlenty specifically mentioned the Council of Health Plans' report card as an example of a document the Smart Buy Alliance will rely on to punish allegedly inferior providers, I want to discuss this report card in some detail. It is grossly inaccurate and should not be relied on by employers or patients.

Last November, the MCHP released a report card they said had been prepared by a group convened by MCHP which adopted the title Community Measurement Project (CMP).[15] The

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[12] Much evidence exists indicating that income can cause differences in the rate at which even *insured* patients get even *inexpensive* services. Franks et al. report, for example, "[L]ower SES [socioeconomic status insured] patients had lower compliance with Pap smears, mammograms, and diabetic eye exams, and were less likely to have a referral or make any office visit.... These income effects are not confined to the poorest patients but span the entire socioeconomic spectrum" (Peter Franks et al., "Effects of patients and physician practice socioeconomic status on the health care of privately insured managed care patients," *Medical Care* 2003;41:842-852, 842).

[13] Jeffrey H. Silver and Paul R. Rosenbaum, "A spurious correlation between hospital mortality and complication rates: The importance of severity adjustment," *Medical Care* 1997;35;OS77-OS92, Supplement, OS87.

[14] Timothy P. Hofer et al., "The unreliability of individual physician 'report cards' for assessing the costs and quality of chronic disease," *Journal of the American Medical Association* 1999;281:2098-2105, 2099. The very small differences in physician effect measured at the physician level would presumably persist at the clinic or medical group or plan level.

[15] Available at http://www.mnhealthcare.org. The Council of Health Plans is coy about how patients are supposed to use the report card. They call their document a "Health Care Quality Report," but they claim they are not recommending that anyone use the report card to compare one clinic to another. That is not how the media is treating this report card (see for example an Associated Press report entitled, "New report will see how health care providers stack up," http://www.kare11.com/news/news_article.aspx?storyid=69022, accessed September 28, 2004).

report card claimed to measure quality of care for several types of patients, including patients with asthma, depression, diabetes, and high blood pressure. It claimed to measure quality by measuring the percent of patients who had gotten certain services or who scored within an acceptable range on certain tests.

Exhibit 1 lists CMP's quality measures for diabetes. You can see this report card includes two types of quality measures – outcome measures and process measures. *Outcome* measures measure changes in patient health, while *process* measures measure how well doctors complied with guidelines. The "percent of diabetics with HbA1c below 8" is an example of an outcome measure (it measures blood sugar levels), while "percent of diabetics with blood sugar test" per year is an example of a process measure.[16]

Exhibit 1: Diabetes care quality measures used by Community Measurement Project include both process and outcome; none are adjusted

Percent with blood sugar test
Percent with HbA1c below 8 percent
Percent with cholesterol test
Percent with cholesterol below 130
Percent with blood pressure under 130/85
Percent not using tobacco
Percent over age 40 who take aspirin daily if appropriate
Percent with regular eye and kidney exams

But this report card is totally unadjusted for risk. The Council of Health Plans did not even bother to adjust scores for age and sex differences, never mind differences in patient health, insurance status, and income. Moreover, by failing to measure physician responses to tests indicating unacceptably high HbA1c counts, blood pressure, and cholesterol counts, the report card further exaggerates the extent to which doctors are providing inferior care. Therefore, if DHS, DOER, or Governor Pawlenty's Smart Buy Alliance were actually to use this report card in deciding which plans to contract with, some patients could be forced or induced to leave good clinics in favor of inferior clinics.

Report cards can damage quality of care by inducing doctors to reject sick patients

Although experts frequently observe that risk-adjustment of report card scores is essential to remove the inducement to physicians to avoid sicker patients, little research to confirm that

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[16] Obviously, outcome measures don't require a standard of care (or a "best practice guideline"), while process measures do. A strict reading of 62J.43, with its constant reference to "best practices," might suggest that the Legislature wanted MDH to develop only measures of how well doctors comply with "best practices," in other words, to develop only *process* measures. I suspect the Legislature did not intend to make such a fine distinction. I assume, in other words, that 62J.43 refers to both outcome measures (for example, what percent of patients survived heart surgery, what percent of patients recovered from depression) and process measures (for example, what percent of heart attack patients received beta blockers and what percent of depressed patients were accurately diagnosed).

assumption has been done. The few studies that have been done confirm this rather obvious assumption.

The study by Hofer et al. I referred to earlier demonstrated how even a rigorously adjusted report card can create an incentive for doctors to avoid sicker patients. The study examined the accuracy of report cards that use blood sugar levels in diabetics, measured by a test of hemoglobin A1c. The authors concluded:

> Ideally, full case-mix models would eliminate or reduce the perverse incentive for physicians to manipulate profiles by electing not to care for sick patients. However, [we found that] if those physicians with the worst profiles . . . for 1991 managed to discourage the patients with the top 5 percent of HbA1c levels (representing only one to three patients per physician) from returning to their panel, they would in most cases achieve a panel HbA1c profile in 1992 that would be substantially improved . . . . . *Manipulating their patient pool, based on a patient's prior year HbA1c level, is the easiest way for physicians to have a substantial improvement in their profile*" (emphasis added).[17]

If rigorously adjusted report cards can induce physicians to reject sicker patients, *a fortiori* poorly or completely unadjusted report cards will have the same effect.[18] Shen found that when Maine began paying its substance abuse providers on a "pay for performance" basis with no risk adjustment of the quality measures, providers quickly rid themselves of their "greatest severity" patients "in order to improve their performance outcomes."[19]

The most compelling evidence that report cards pose a threat to patients comes from the professional literature on the report card published by New York's Department of Health on cardiac surgeons and hospitals. This report card was the first to measure quality at the physician level; it is considered to be the most accurate report card in the country; and it is the most extensively studied report card.[20] And yet the evidence indicates this report card has severely

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[17] Hofer et al., op cit., 2103.

[18] Dr. Michael Ainslie, a pediatrician with Park Nicollet Clinic who is board chair of the Hennepin Medical Society and current treasurer of the Minnesota Medical Association, stated in a roundtable organized by *Minnesota Physician*, "If [an HbA1c guideline] is used as a stick, I can guarantee you I will change my practice and not accept anybody with a hemoglobin A1c of less than 8.5 if that is the target" ("Minnesota Health Care Roundtable," *Minnesota Physician*, January 2005, 20, 22).

[19] Yujing Shen, "Selection incentives in a performance-based contracting system," *Health Serv Res* 2003;38:535-552, 535.

[20] "New York State's measurement and publication of coronary artery bypass graft (CABG) surgery mortality rates has emerged as a model in the campaign for useful performance data. The reality is that these measures of performance are ... the best available, and that substantial improvements are not likely for some years" (Stephen F. Jencks, "Clinical performance measurement – a hard sell," *JAMA* 2000;283:2015-2016, 2015, 2016).

"The New York state Department of Health developed the first physician-specific mortality reports ever published when it initiated the Cardiac Surgery Reporting System (CSRS) in 1991. This project has been the most controversial and the most studied of any statewide project" (Bradley J. Harlan, "Statewide reporting of coronary artery surgery results: A view from California," *Journal of Thoracic and Cardiovascular Surgery* 2001;121:409-417, 409-410).

". . . . CSRS [Cardiac Surgery Reporting System, the system used by the New York Department of Health] became the first profiling system with sufficient clinical detail to generate credible comparisons of providers' outcomes. For this reason, CSRS has been recognized as the gold standard among systems of its kind." (Jesse

damaged the health of sicker patients because New York's heart surgeons are refusing to treat sicker patients. They are rejecting sicker patients because these patients are more likely to die within 30 days of surgery and doctors believe the report card won't accurately adjust – that is, give lower weight to – the deaths of these sicker patients.

Exhibit 2 indicates the New York report card adjusts 72 factors outside of surgeon (or hospital) control that could affect mortality rates. Exhibit 3 indicates, as you might expect, that collecting and crunching all the data necessary to adjust mortality rates for 72 factors is expensive. The exhibit indicates that approximately 40 full-time staff are required to produce the report card – six staff at the New York Department of Health, and approximately one full-time data coordinator for each of the 36 hospitals graded in the latest report card. I have never seen an

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Exhibit 2: New York's heart surgery report card is rigorously adjusted

72 risk factors are adjusted
They include:

* number of coronary arteries occluded and degree of occlusion
* previous heart attack
* hemodynamic state just prior to surgery (ability to maintain blood pressure)
* chronic obstructive pulmonary disease
* kidney failure
* smoking history (last two weeks, last year)

Source: Edward L. Hannan et al., "Public release of cardiac surgery outcomes data in New York: What do New York state cardiologists think of it?," *Am Heart J* 1997;134;55-61.

Exhibit 3: The New York's heart surgery report card is expensive

The New York Department of Health pays for:

* "five full-time equivalent staff maintaining the database..." and
* "a utilization review agent ... to audit a sample of 50 cases from half the hospitals each year."

The three dozen heart surgery hospitals in NY pay for:

"data coordinators to collect and maintain their databases; most hospitals have a full-time coordinator dedicated to this task."

Source: Edward L. Hannan et al., "Public release of cardiac surgery outcomes data in New York: What do New York state cardiologists think of it?" *Am Heart J* 1997;134:55-61, 62.

Greenfield and Neil Wintfeld, "Report cards on cardiac surgeons: Assessing New York State's approach," *New England Journal of Medicine* 1995;332(18):1229-1232, 1230).

estimate of the total cost of this report card, but the cost for the staff alone, never mind the computers and software, runs into the millions annually.

Anecdotal evidence that the New York report card would induce doctors to avoid sicker patients materialized immediately after the release of the first report card in 1991.[21] The *New York Times* reported in 1995 that even the number-one ranked cardiac surgeon did not believe the report card was accurate.[22] In 2003, the *New York Times Magazine* reported, "The incentive to refuse treatment for high-risk patients has created a kind of spiritual crisis in the field of cardiac surgery. Heart surgeons ... are shrinking from taking on the toughest cases because of statistics."[23]

But by the mid-1990s, empirical research confirming the anecdotal evidence began to be published. A convincing study confirming the early studies appeared in 2003. Four researchers at Stanford and Northwestern, including by Mark McClellan, George Bush's director of the Centers for Medicare and Medicaid Services, published a paper on the New York report card that year in which they reached this conclusion: "Taken together, our results show that report cards [on heart surgeons] led to . . . marginal health benefits for healthy patients, and major adverse health consequences for sicker patients."[24] "[M]ore severely ill ... patients experienced dramatically worsened health outcomes."[25] The authors contradicted earlier studies that reported that New York's CABG mortality rate dropped after the report card began to be published.[26] The authors stated that widespread refusal to operate on sicker patients by surgeons caused an artificial decline in New York's CABG mortality rate. "Report cards led to a decline in the illness severity of patients receiving CABG in New York ... relative to patients in states without report cards," the authors wrote.[27]

Studies reaching similar conclusions about New York's *angioplasty* report card, introduced in the mid-1990s, are now appearing. Just last month, a study was published indicating 79 percent of New York cardiologists have refused to operate on patients who might have benefited

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[21] "The [December 19, 1991] *Newsday* article stated that several surgeons warned that some surgeons were turning down difficult cases to protect their statistics" (p. 410). "[A]n article appeared in the *New York Times* [in 1992] entitled 'Faint hearts.' As fate would have it, a woman was turned down for surgery because she had a fresh, large myocardial infarction. Her daughter was a reporter for the *New York Times*. After great difficulty, the daughter eventually found a surgeon who would operate on her mother" (p. 411) (Bradley J. Harlan, "Statewide reporting of coronary artery surgery results: A view from California," *J Thorac Cardiovasc Surg* 2001;121(3):409-17).

[22] "'[T]here is nothing that separates me from the rest of the people on the list,' Dr. [Jeffrey] Gold said.... And even though Dr.Gold is ranked at the top of the [1994] report, he has qualms about it. 'I'm concerned about the predictability of it,' he said. 'I certainly would not use it as the sole way of selecting an institution or a surgeon'" (Elisabeth Bumiller, "Death rankings shake New York cardiac surgeons," *New York Times*, September 6, 1995, A1, B11).

[23] Sandeep Jauhar, "When doctors slam the door: Under the current system, a doctor's reputation may depend on his or her willingness to turn away a dying man," *New York Times Magazine*, March 16, 2003, 30, 34.

[24] David Dranove, Daniel Kessler, Mark McClellan, and Mark Satterthwaite, "Is more information better? The effects of 'report cards' on health care providers," *J Pol Econ* 2003;111:555-588, 577.

[25] Ibid, 583.

[26] See for example Source: Edward L. Hannan et al., "Improving the outcomes of coronary artery bypass surgery in New York State," *Journal of the American Medical Association*, 1994;271:761-766, Table 3, 763.

[27] Ibid.

from angioplasty because they were worried their ranking on the angioplasty report card would suffer unfairly.[28]

Report cards can damage quality of care by inducing plans and providers to shift resources away from patients receiving unmeasured services.

It is human nature to shift resources away from activities that are not rewarded to those that are. Recognition of this fact is, after all, why teachers around the world do not tell students what questions will appear on examinations. Report cards on quality of care will probably damage quality by inducing plans and providers to shift resources from unmeasured services to measured services. This would not occur if report-card publishers released report cards on the 10,000-plus medical services available today. But that, it is safe to predict, will never happen.

This "teaching to the test" phenomenon (in a medical context, perhaps it should be called "practicing to the report card") has attracted little research, but what evidence there is indicates plans and providers do shift resources away from unmeasured services. Lee-Feldstein et al. uncovered such evidence in the course of investigating whether HMO physicians detected breast and colorectal cancer in Medicare patients earlier than fee-for-service (FFS) physicians. They discovered that HMO patients were much more likely to have breast cancer detected early but FFS patients were much more likely to have colorectal cancer diagnosed early. The authors noted that the nation's most pervasive HMO report card, the Health Plan Employer Data Set (HEDIS) run by the National Committee for Quality Assurance, graded HMOs on mammography rates but not on a corresponding screen for colorectal cancer. "This suggests that preventive screening for conditions such as colorectal cancer that are not required to be in a report card (such as HEDIS) are more likely to be neglected," the authors concluded.[29]

Other observers have taken note of the problem. Here are two examples:

> [I]f providers face a number of tasks and resources are limited, then effort will be allocated toward those tasks that are explicitly rewarded, taking resources away from other activities. Inevitably, . . . the dimensions of care that will receive the most attention will be those that are most easily measured and not necessarily those that are most valued.[30]

> Anecdotally, those in the know routinely report that plans will turn themselves inside out to be able to report "good" HEDIS data. These data apparently come at the expense of other parallel quality initiatives.[31]

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[28] Marc Santora, "Cardiologists say rankings sway choices on surgery," *New York Times*, January 11, 2005, A18.

[29] Anna Lee-Feldstein, Paul J. Feldstein, and Thomas Buchmueller, "Health care factors related to stage at diagnosis and survival among Medicare patients with colorectal cancer," *Med Care* 2002;40:362-374, 374.

[30] Meredith B. Rosenthal, Rushika Fernandopulle, HyunSook Ryu Song, and Bruce Landon, "Paying for quality: Providers' incentives for quality improvement," *Health Aff* 2004;23(2):127-141,139.

[31] Alice Gosfield, "Who is holding whom accountable for quality?" *Health Aff* 1997;16(3):36.

Inaccurate report cards are misleading policymakers, reporters, and the public

In addition to steering patients to inferior providers, inducing doctors to reject sicker patients, and inducing plans and providers to shift resources away from ungraded patients, inaccurate report cards damage patients in a less direct manner, namely, by grossly exaggerating the unacceptability of medical care and thereby inducing policymakers, foundations, and researchers to waste money on relatively minor problems that might have otherwise have been spent on patients or on more effective forms of quality improvement. A study by Kerr et al., summarized in Exhibit 4, illustrates this problem. Using the identical quality measure for cholesterol used by MCHP (percent of diabetics with LDL cholesterol under 130), Kerr et al. demonstrated that taking into account just a few factors outside of physician control, as well as actions physicians take in response to high cholesterol readings, substantially alters the quality-of-care scores for physicians who treat diabetics. Kerr found that the percent of diabetics receiving "quality" medical care rose from 73 percent to 90 percent and possibly higher.

Kerr et al. found 73 percent of a sample of patients treated at two VA hospitals had cholesterol readings under 130. However, the authors went beyond this simple measure of quality and asked two other questions: (1) Did doctors respond to high cholesterol readings by changing the patient's medication (prescribing a statin for patients without a prescription, or changing the type or strength of the statin for those already taking a statin); and (2) Did the patients have contraindications for statins? When answers to these two questions were added to the definition of quality care, Kerr et al. found that 87 percent of diabetics had received quality care. When Kerr et al. took into account other legitimate responses by physicians and patients to high cholesterol readings (including dieting and exercising), as well as a few factors outside physician control (for example, patients not returning to see their doctor after a high-cholesterol reading, and patients refusing to take statins), the percent of diabetics deemed to have received "quality" care rose even higher – to 90 percent. The authors did not attempt to investigate other factors that might have explained the remaining 10 percent.

The Kerr study demonstrates that the Council of Health Plans' diabetes report card is misleading not only because no attempt was made to risk-adjust the medical groups' grades for

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Exhibit 4: "Quality-of-care" scores for diabetics for different definitions of quality

Definition of quality	% patients meeting definition
(1) Cholesterol under 130	73%
(2) Measure (1) + doctor has responded to high reading, + patient has contraindications to statins	87%
(3) Measures (1) + (2) + other factors*	90%

* "Other factors" included: patient refuses to take lipid-lowering medications; lipid management low priority or difficult to address; no primary care visit after high reading; has active care elsewhere; other interventions tried within six months of high reading (diet, exercise, or other lipid-lowering drug).

Source: Eve Kerr et al., "Building a better quality measure: Are some patients with 'poor quality' actually getting good care?" *Medical Care* 2003;41:1173-1182.

factors outside physician control, but because the report card uses a very restricted menu of quality measures that overlooks factors within physician control, including taking steps to bring cholesterol levels down once a blood test has confirmed a high cholesterol level. According to MCHP's report card, 40 percent of Minnesota diabetics do not have their cholesterol under control. Because MCHP refers to its entire report card as a report on "quality," most readers will assume Minnesota doctors are failing to provide evidence-based medicine to 40 percent of all diabetics. A more rigorous analysis, such as that by Kerr et al., would almost certainly demonstrate the 40 percent figure is wildly off the mark as a measure of quality of care. A more rigorous study of diabetes care would probably indicate that Minnesota policymakers could do far more to improve quality of care if they focused less on doctors and more on factors outside physician control, such as inadequate health insurance and health illiteracy among diabetics.[32]

Reports on numbers of procedures

It is important to distinguish public information on the number of procedures a hospital or physician performs from report cards that purport to measure quality directly. A report on numbers of procedures performed can be a useful guide to quality if the procedure in question is one of a dozen procedures for which a volume-quality correlation has been shown. Pancreatic cancer surgery, coronary bypass surgery, and angioplasty are examples of such procedures.[33]

Reports on numbers of procedures pose none of the three risks to patients reviewed above – inaccuracy, inducing doctors to reject sicker patients, and inducing providers to shift resources from unmeasured to measured services. It is easy to achieve accuracy in numbers-of-procedures reports. (One need only count up the number of operations done each year; adjusting outcomes for patient differences and finding an agreed-upon standard-of-care with which to construct a process measure becomes irrelevant.) Doctors might disagree with studies that show a volume-quality correlation for a given procedure, but they can have no doubt about the accuracy of volume-of-procedure counts themselves and, therefore, would have no incentive to refuse services to sicker patients.

Quality improvement does not inevitably lead to lower costs

The claims by the Legislature and the Governor that report cards will lead to quality improvement, and improvements in quality must lead to lower costs, must be treated at this point as speculation. As the data on New York's report card indicates, the cost of numerous *accurate* report cards published on a regular basis will be immense. Moreover, there is no guarantee that quality improvement will lead to lower costs. Underuse of health care services is far more prevalent than overuse. According to a recent study by the RAND Corporation, "Underuse of

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[32] For a discussion of other obstacles report cards face, see: Louise C. Walter et al., "Pitfalls of converting practice guidelines into quality measures: Lessons learned from a VA performance measure," *JAMA* 2004;291:2466-2470; Bruce E. Landon et al., "Physician clinical performance assessment: Prospects and barriers," *JAMA* 2003;290:1183-1189; Thomas G. DiSalvo et al., "Pitfalls in assessing the quality of care for patients with cardiovascular diesease," Am J Med 2001;111:297-303; Rachel Sorokin, "Alternative explanations for poor report card performance," *Effective Clinical Practice* 2000; 3(1):25-30;

[33] Kenneth W. Kizer, "The volume-outcome conundrum," *New Engl J Med* 2003;349:2159-2161.

care was a greater problem than overuse. [P]atients failed to receive recommended care about 46 percent of the time, compared with 11 percent of the time when they received care that was not recommended and potentially harmful."[34] Thus, even if report cards could lead to the elimination of both overuse and underuse, the effect would quite probably be to add to total health care spending.

Conclusions

None of the three threats to patients created by report cards would exist if grades from quality measurements were not used to punish low-scoring doctors, clinics, hospitals, or plans. But that is what this legislature and our current governor are proposing to do. It is conceivable that simply sharing scores with the clinics, hospitals or plans involved might produce useful hypotheses for quality improvement for some providers or plans. This is conceivable even for grossly inaccurate measurements such as those used by the Minnesota Council of Health Plans. A low-scoring clinic, for example, might, upon investigation, discover that its low scores were due to factors within, not outside, its control. It is the use of report cards, even reasonably accurate report cards, *for the purpose of punishing low scorers* that creates the risk to patients documented in this paper. The mere publication of scores may constitute embarrassment (a form of punishment) even if patients and employers give little credence to the report card. If patients and employers take the advice of this Legislature and shop based on report cards, publication will do more than merely embarrass providers; they will punish providers financially. Policy-makers, in short, should treat publication itself as a form of punishment and, therefore, as an act which creates the risk of harming patients.

Obviously, a state law *requiring* state agencies to punish low-scorers on report cards (such as that proposed in SF 65) guarantees that punishment will include financial loss, not just embarrassment. Similarly, an alliance of insurance purchasers with as much market clout as the Smart Buy Alliance has the ability to guarantee that some providers and plans that score poorly on report cards will suffer financially. In short, *SF 65 and the announced plans of the Smart Buy Alliance virtually guarantee that Minnesota patients will be exposed to the three risks created by report cards discussed in this paper.*[35]

The Legislature and the Governor must view report cards the way the FDA and the public view a new, untested drug: Report cards have the potential to improve quality for some patients, and they have the potential to create serious negative side effects for some patients, but until report cards have been tested on small groups to determine their safety and effectiveness, they

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[34] RAND Corporation News release: "How good is the quality of health care in America?," describing data in Elizabeth A. McGlynn et al., "The quality of health care delivered to adults in the United States," *New England Journal of Medicine* 2003; 348 (26): 2635-2645, http://www.rand.org/news/press.03/06.25fact.html, accessed November 11, 2004. The study was based on interviews with 13,000 Americans in 12 cities. 6,700 of these consented to reviews of their medical records.

[35] Section 62J.43, on the other hand, does not by itself create those risks. Section 62J.43 does not require anyone to use report cards that MDH is authorized to publish, and does not require state agencies to punish plans and providers that score low on report cards. Thus, depending on how MDH, DOER, and DHS use the authority given them by Section 62J.43, it is possible that 62J.43 by itself will not damage quality of care in any of the three ways I have discussed in this paper.

should not be used on the population at large. To carry the analogy a step further, policymakers should view report cards as the equivalent of a me-too drug (a drug that merely copies numerous drugs already on the market). Proponents of report cards create the impression that there simply is no other way to improve quality, and if report cards are not unleashed on the populace, quality will never improve. This is false. A very strong argument can be made for shifting all but a tiny fraction of the money now being spent on report cards into a half-dozen other quality-improvement projects, including

(1) reducing the number of uninsured and underinsured,
(2) lowering the cost of medical care, especially drugs,
(3) ending the nurse shortage,
(4) improving doctor-patient decision-making with old-fashioned medical research and public education about the results of that research,
(5) funding nurses and social workers to coach chronically ill patients who have trouble complying with physician recommendations, and
(6) computerizing prescription ordering.

Removing authority over medical decision-making from insurance companies and restoring it to doctors and patients would also improve overall quality.[36]

I close by noting the obvious: If report cards cannot improve overall quality, the expense of preparing report cards will simply raise total health care costs; if report cards damage overall quality, that too will probably raise total health care spending. Until we have evidence demonstrating the safety and effectiveness of report cards, and until we have evidence indicating that improvements in quality inevitably lead to lower costs, the Legislature and Governor should stop treating report cards as a cost-containment solution.

Appendix A: Examples of statements by experts that risk adjustment of report card grades is essential

"The interpretation of outcomes is further complicated by the need to make adjustments for comorbidity and the intensity and state of the patient's illness – a far from trivial undertaking."

Paul Ellwood ("Outcomes management: A technology of patient experience," *New England Journal of Medicine* 1988;318:1549-1556).

"[T]he importance of co-morbidity must be stressed. . . . If co-morbidity is not considered, there will always be the potential for individual providers or centers to be unjustly accused of poor quality because of patient selection; academic centers in some areas may be particularly susceptible to such bias."

Richard W. Asinger, MD ("Constructive use of clinical databases," *The Medical Journal of Allina*, 1996(1):31-34, 32).

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[36] Kip Sullivan, "Managed care plan performance since 1980: Another look at two literature reviews," *American Journal of Public Health* 1999;89:1003-1008.

"For reports on the performance of health care providers to be effective, profiling must be done using the best statistical methods. . . . Case-mix adjustments are made in almost all profile analyses to account of the differences in provider performance attributable solely to differences in the populations served" (p. 764). "Risk adjustments contribute vitally to reducing unfair profile evaluations" (765).

Cindy L. Christiansen and Carl N. Morris ("Improving the statistical approach to health care provider profiling," *Ann Intern Med* 1997;127:764-768).

"Accurate risk adjustment is necessary for observational and health services research, including comparison of outcomes of different treatments and quality assessment."

Jay F. Piccirillo et al. ("Prognostic importance of comorbidity in a hospital-based cancer registry," *JAMA* 2004;291:24241-47).

"[I]n-depth chart reviews and even patient interviews should regularly supplement most quantitative measures of quality to ensure that such measures are capturing meaningful information and that problems with the measures are identified and fixed . . . . .In addition, detailed clinical information is required to determine what should be done to improve the quality of care, since simply reporting screening rates conceals the details needed to inform policy changes."

Louise C. Walter et al. ("Pitfalls of converting practice guidelines into quality measures: Lessons learned from a VA performance measure," *JAMA* 2004;291:2466-70).

"Risk adjustment may be only partially successful, so differences in risk-adjusted mortality may reflect differences in patient health rather than quality of care. We found that patient characteristics were 315 times more important than hospital characteristics in predicting mortality after simple surgery, so small errors in risk adjustment may loom large compared to hospital differences."

Jeffrey H. Silver and Paul R. Rosenbaum ("A spurious correlation between hospital mortality and complication rates: The importance of severity adjustment," *Medical Care* 1997;35;OS77-OS92, Supplement, OS87.)

Excerpts from Diabetes Quality Improvement Project's criteria for report cards:

> "2D. Risk adjustable. If the measure is being used for comparison, either the measure should not be appreciably affected by any variables that are beyond the plan's/provider's control ("covariates"), or any extraneous factors should be known, they should be measurable, and *there should be validated models for calculating an adjusted result that corrects for the effects of covariates*. The population characteristics of varying delivery systems should be understood, in that the measure should be applicable to different settings, where the population may be different in terms of size, disease or other characteristics. . . . . [emphasis added]

Diabetes Quality Improvement Project (*Diabetes Quality Improvement Project Initial Measure Set (Final Version)*, http://www.ncqa.org/DPRP/dqip2.htm, accessed March 27, 2004).

MINNESOTA PROGRAMS WITH PRESCRIPTION DRUG BENEFITS

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MinnesotaCare
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MEDICARE DISCOUNT CARD AND MEDICARE PART D PRESCRIPION DRUG BENEFIT (MMA)

On January 1, 2006, the Medicare prescription drug benefit will offer all Medicare-eligible patients prescription drug coverage.

Medicare is already providing seniors with access to prescription drugs through discount drug cards. All those Medicare eligible residents of the state who do not qualify for another program have access to the cards, which offer 15 to 25 percent, or more, discounts on all drugs.

To receive information on how to sign up for the Medicare program call 1- 800-MEDICARE (1-800-633-4227) or go on the internet at www.medicare.gov or www.abcrx.org

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/ aringhouse program through the Minnesota Board on Aging. This program helps Minnesota c..ens access free and discounted medicines. In 2004, 45,530 total applications assisted with all RxConnect™ related programs. To contact RxConnect call 1-800-333-2433 or go the website www.mnaging.org.

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Together Rx-- is a prescription drugs savings program that offers **Medicare eligibles** a free, easy way to save approximately 20% to 40% on brand-name medicines and , in many cases, much more. You can save on more than 155 FDA-approved medicines and some pharmacies even offer savings on generics. The program is offered by 7 companies. Individuals and couples up to 300% FPL without

illyAnswers-- the program offers a flat $12 fee for a 30-day supply of any Lilly retail drug, which ould provide up to $600 in annual savings for eligible citizens. U.S. citizens whose annual ıdividual income falls below $18,000 — or whose household income is less than $24,000 — are ligible for LillyAnswers. Medicare-enrolled seniors and persons with disabilities also are eligible to pply for a LillyAnswers card. LillyAnswers currently has over 230,000 members and, in 2003, rovided more than 630,000 prescriptions valued at $67 million.For additional information please all 1-877-RX-LILLY or visit the website at www.lillyanswers.com

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'harmaceutical manufacturers already pay the state millions of dollars each year in federally-ıandated Medicaid rebates and state supplemental rebates for the Medicaid program. In 2005, it is stimated that the pharmaceutical industry will pay **a total of over $80 million** for the Minnesota Medicaid program.

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