

Senate File 1760 As Passed by the MN Senate 4/7/04 in House File 2028 (the SF 1760 language passed the Senate in and now exists as part of HF 2028 - the unengrossed version #2 if you're looking for it online). Although confusing, it is a simple substitution maneuver. HF 2028 was a House bill passed by the House and sent to the Senate that the Senate then used as a vehicle for their own language: the combined Senate Supplemental Budget Bill. They simply deleted all the House language and substituted their own.

- bolding used by CCHC to facilitate location of terms

Article 20

360.3 Sec. 8. [62J.43] [**BEST PRACTICES AND QUALITY IMPROVEMENT.**]

360.4 (a) To improve quality and reduce health care costs, state

360.5 agencies shall encourage the adoption of best practice

360.6 guidelines and participation in best practices measurement

360.7 activities by physicians, other health care providers, and

360.8 health plan companies. The commissioner of health shall

360.9 facilitate access to best practice guidelines and quality of

360.10 care measurement information to providers, purchasers, and

360.11 consumers by:

360.12 (1) identifying and promoting local community-based,

360.13 physician-designed best practices care across the Minnesota

360.14 health care system;

360.15 (2) disseminating all information available to the

360.16 commissioner on adherence to best practices care by physicians

360.17 and other health care providers in Minnesota;

360.18 (3) educating consumers and purchasers on how to

360.19 effectively use this information in choosing their providers and

360.20 in making purchasing decisions; and

360.21 (4) making all best practices and quality care measurement

360.22 information available to enrollees and program participants

360.23 through the Department of Health's Web site. The commissioner

360.24 may convene an advisory committee to ensure that the Web site is

360.25 designed to provide user friendly and easy accessibility.

360.26 (b) The commissioner of health shall collaborate with a

360.27 nonprofit Minnesota quality improvement organization

360.28 specializing in best practices and quality of care measurements

360.29 to provide best practices criteria and assist in the collection

360.30 of the data.

360.31 (c) The initial best practices and quality of care

360.32 measurement criteria developed shall include asthma, diabetes,

360.33 and at least two other preventive health measures. Hypertension

360.34 and coronary artery disease shall be included within one year

360.35 following availability.

360.36 (d) The commissioners of human services and employee

361.1 relations shall use the data to make decisions about contracts

361.2 they enter into with health plan companies and shall establish

361.3 payment withholds based on best practices and quality of care

361.4 measurements as part of the contracts in effect January 1,

361.5 2005. The health plan companies may pass the withholds through

361.6 to physicians and other health care providers if the physician
361.7 or health care provider fails to follow the best practices and
361.8 quality of care measurement criteria identified in this
361.9 section. The withholds established by the commissioner of human
361.10 services shall be included with the withholds described in
361.11 sections 256B.69, subdivision 5a, and 256L.12, subdivision 9.
361.12 If a payment withhold is passed through, a provider may not
361.13 terminate an existing contract with a health plan company based
361.14 solely on this withhold.

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

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

361.23 Subdivision 1. [GENERAL PROVISIONS.] (a) The legislature
361.24 finds that there is a need to advance the use of electronic
361.25 medical record systems by health care providers in the state in
361.26 order to achieve significant administrative cost savings and to
361.27 improve the safety, quality, and efficiency of health care
361.28 delivery in the state. The legislature also finds that in order
361.29 to advance the use of an electronic medical record system in a
361.30 cost-effective manner and to ensure an electronic medical record
361.31 system's interoperability and compatibility with other systems,
361.32 the state needs to develop a standard, definitional model of an
361.33 electronic medical record system that includes uniform formats,
361.34 data standards, and technology standards for the collection,
361.35 storage, and exchange of electronic health records. These
361.36 standards must be nationally accepted, widely recognized, and
362.1 available for immediate use.

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

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

362.21 support.

362.22 Subd. 2. [MODEL ELECTRONIC MEDICAL RECORD SYSTEM.] (a) The

362.23 commissioner of health, in consultation with the Minnesota

362.24 Administrative Uniformity Committee, shall develop a functional

362.25 model for an electronic medical record system according to the

362.26 following schedule:

362.27 (1) by October 1, 2005, the commissioner shall develop a

362.28 model system that provides immediate, electronic on-site access

362.29 to complete patient information, including information necessary

362.30 for quality assurance at the point of care delivery;

362.31 (2) by October 1, 2005, the commissioner shall develop

362.32 standards for secure Internet or other viewing-only access to

362.33 patient medical records that require the patient to provide

362.34 access information to an off-site provider and do not allow

362.35 interaction with the records; and

362.36 (3) by January 15, 2006, the commissioner shall develop

363.1 standards for interoperable systems for sharing and

363.2 synchronizing patient data across systems. The standards must

363.3 include a requirement for a secure, **biometric patient**

363.4 **identification** system to ensure access security and identity

363.5 authentication and shall require patient consent prior to the

363.6 sharing of patient data across systems. In creating the

363.7 infrastructure of the system, the model must include the

363.8 development of uniform data standards in terms of clinical

363.9 terminology, the exchange of data among systems, and the

363.10 representation of medical information and must include the

363.11 development of a common set of requirements for functional

363.12 capabilities for the system software components. The uniform

363.13 standards developed must be functional for use by providers of

363.14 all disciplines and care settings. The standards must also be

363.15 compatible with federal and private sector efforts to develop a

363.16 **national electronic medical record** and must incorporate existing

363.17 standards and state and federal regulatory requirements. In

363.18 developing a model, the commissioner shall consider data privacy

363.19 and security concerns and must ensure compliance with federal

363.20 and state law.

363.21 (b) The commissioner of human services shall convene an

363.22 advisory committee with representatives of safety-net hospitals,

363.23 community health clinics, and other providers who serve

363.24 low-income patients to address their specific needs and concerns

363.25 regarding the establishment of an electronic medical record

363.26 system within their hospital or practice setting. As part of

363.27 addressing the specific needs of these providers, the

363.28 commissioner shall explore the implementation of an accessible

363.29 interactive system created collaboratively by publicly owned

363.30 hospitals and clinics. The commissioner shall also explore

363.31 financial assistance options, including bonding and federal

363.32 grants.

363.33 (c) The commissioner shall report to the legislature by

363.34 January 15, 2005, on the progress in the development of uniform

363.35 standards and on a functional model for an electronic medical
363.36 record system.

369.6 Sec. 15. [QUALITY IMPROVEMENT.]

369.7 The commissioners of human services and employee relations
369.8 shall jointly develop a written plan for a provider payment
369.9 system to be implemented by July 1, 2005. Under the provider
369.10 payment system, a **minimum of five percent of a provider's**
369.11 **payment shall be withheld.** Return of the withhold to a provider
369.12 will be conditioned on the provider achieving certain quality
369.13 improvement performance standards. The commissioners shall
369.14 consult with local and national quality improvement groups to
369.15 identify appropriate standards and measures related to
369.16 **performance.**

Sec. 25. Minnesota Statutes 2002, section 256B.0625, is

392.17 amended by adding a subdivision to read:

392.18 Subd. 46. [LIST OF HEALTH CARE SERVICES NOT ELIGIBLE FOR

392.19 COVERAGE.] (a) The commissioner of human services, in

392.20 consultation with the commissioner of health, shall biennially

392.21 establish a list of diagnosis/treatment pairings that are not

392.22 eligible for reimbursement under this chapter and chapters 256D

392.23 and 256L, effective for services provided on or after July 1,

392.24 2005. The commissioner shall review the list in effect for the

392.25 prior biennium and shall make any additions or deletions from

392.26 the list as appropriate, taking into consideration the following:

392.27 (1) scientific and medical information;

392.28 (2) clinical assessment;

392.29 (3) cost-effectiveness of treatment;

392.30 (4) prevention of future costs; and

392.31 (5) medical ineffectiveness.

392.32 (b) The commissioner, after receiving recommendations from

392.33 professional medical associations, may designate a medical

392.34 director and medical policy committee to advise the commissioner

392.35 on clinical issues such as **best practice guidelines**, utilization

392.36 control, and disease management and care coordination strategies

393.1 for the medical assistance, general assistance medical care, and

393.2 MinnesotaCare programs. If the commissioner designates a

393.3 medical director, the medical director shall be a physician who

393.4 works as an employee or contractor for the Department of Human

393.5 Services. If the commissioner convenes a medical policy

393.6 committee, the committee shall consist of the medical director

393.7 and nine members, seven of whom shall be physicians licensed to

393.8 practice in Minnesota, and two of whom shall be nonphysician

393.9 health professionals licensed to practice in Minnesota. Except

393.10 for the medical director, the medical policy committee members

393.11 shall not be employees of the Department of Human Services,

393.12 shall serve three-year terms, and may be reappointed once. The

393.13 commissioner shall appoint the initial members of the committee

393.14 for terms expiring as follows: three members for terms expiring
393.15 June 30, 2005, three members for terms expiring June 30, 2006,
393.16 and three members for terms expiring June 30, 2007.
393.17 The medical director and medical policy committee may
393.18 assist the commissioner in reviewing and establishing the list.
393.19 The commissioner shall solicit comments and recommendations from
393.20 any interested persons and organizations and shall schedule at
393.21 least one public hearing.
393.22 (c) The list must be established by January 15, 2006, for
393.23 the list effective October 1, 2006, and by October 1 of the
393.24 even-numbered years thereafter. The commissioner shall publish
393.25 the list in the State Register by November 1 of the
393.26 even-numbered years beginning November 1, 2008. The list shall
393.27 be submitted to the legislature by January 15 of the
393.28 odd-numbered years beginning January 15, 2007.

393.29 Sec. 26. [256B.075] [DISEASE MANAGEMENT PROGRAMS.]

393.30 Subdivision 1. [GENERAL.] The commissioner shall design
393.31 and implement a disease management and care coordination
393.32 initiative for the medical assistance, general assistance
393.33 medical care, and MinnesotaCare programs. The initiative shall
393.34 provide an integrated and systematic approach to manage the
393.35 health care needs of recipients who are at risk of, or diagnosed
393.36 with, specified conditions or diseases that require frequent

394.1 medical attention. The initiative shall seek to improve patient
394.2 care and health outcomes and reduce health care costs by
394.3 managing the care provided to recipients with chronic conditions.

394.4 Subd. 2. [FEE-FOR-SERVICE.] (a) The commissioner shall
394.5 develop and implement a disease management and care coordination
394.6 program for medical assistance and general assistance medical
394.7 care recipients who are not enrolled in the prepaid medical
394.8 assistance or general assistance medical care program and who
394.9 are receiving services on a fee-for-service basis.

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

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

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

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

394.27 (3) educating the patient in self-management and the

394.28 importance of adhering to the care plan;
394.29 (4) providing problem follow-up and new assessments, as
394.30 needed; and
394.31 (5) adhering to evidence-based **best practices** care
394.32 strategies.
394.33 (d) The care coordinator or primary care provider may
394.34 create incentives for a recipient to ensure cooperation and
394.35 patient engagement in the care plan and management.
394.36 (e) The recipient shall be required to seek health care
395.1 services related to a specific diagnosis identified in paragraph
395.2 (b) from the care coordinator or primary care provider or from
395.3 the providers on the recipient's care team.
395.4 (f) The commissioner shall set a cost-savings target of ten
395.5 percent reduction in inpatient hospitalization and emergency
395.6 room costs for fiscal year 2005. Based on the achievement of
395.7 this goal, one-half the savings shall be used as a bonus to the
395.8 participating primary care providers for the following fiscal
395.9 year. The bonus shall be paid on a quarterly basis and shall be
395.10 based on the percentage of patients treated by the provider who
395.11 have been identified by the commissioner in accordance with this
395.12 subdivision.
395.13 (g) The commissioner shall seek any federal waivers or
395.14 state plan amendments necessary to implement this section and to
395.15 obtain federal matching funds.
395.16 Subd. 3. [MANAGED CARE CONTRACTS.] (a) The commissioner
395.17 shall require all managed care plans entering into contracts
395.18 under section 256B.69 to develop and implement at least three
395.19 disease management programs that will improve patient care and
395.20 health outcomes for those enrollees who are at risk of or
395.21 diagnosed with a chronic condition.
395.22 (b) The commissioner shall require the managed care plans
395.23 to measure and report outcomes according to measurements
395.24 approved by the commissioner. In determining outcome
395.25 measurements, the commissioner shall establish a baseline
395.26 indicating the prevalence of each disease identified in
395.27 paragraph (a) in the general population and within identified
395.28 racial or ethnic groups. The managed care plan must report the
395.29 number of enrollees who are at risk based on the baseline
395.30 measurement; the number of enrollees who have been diagnosed
395.31 with the disease; and the number of enrollees participating in
395.32 the managed care plan's disease management program.
395.33 (c) The commissioner shall establish targets based on the
395.34 number of enrollees who should be receiving disease management
395.35 services as determined by the prevalence of the disease within
395.36 the general population and the number of enrollees who are
396.1 receiving disease management services. The targets must also
396.2 include a specified reduction in inpatient hospitalization costs
396.3 and in the progression of the chronic diseases for the enrollees
396.4 identified as being at risk of or diagnosed with a chronic
396.5 condition.
396.6 Subd. 4. [HEMOPHILIA.] The commissioner shall develop a

396.7 disease management initiative for public health care program
396.8 recipients who have been diagnosed with hemophilia. In
396.9 developing the program, the commissioner shall explore the
396.10 feasibility of contracting with a section 340B provider to
396.11 provide disease management services or coordination of care in
396.12 order to maximize the discounted prescription drug prices of the
396.13 federal 340B program offered through section 340B of the federal
396.14 Public Health Services Act, United States Code, title 42,
396.15 section 256b (1999).

Sec. 46. [DISEASE MANAGEMENT PROGRAM ACCOUNTABILITY.]

431.19 Any savings generated from the disease management
431.20 initiatives under Minnesota Statutes, section 256B.075, shall be
431.21 retained by the commissioner of human services and used for
431.22 provider bonuses in the fee-for-service medical assistance
431.23 program as described in Minnesota Statutes, section 256B.075,
431.24 and for increasing other provider rates within the
• fee-for-service program.

Sec. 48. [LIMITING COVERAGE OF HEALTH CARE SERVICES FOR

432.8 MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND
432.9 MINNESOTACARE PROGRAMS.]

432.10 Subdivision 1. [GENERAL ASSISTANCE MEDICAL CARE AND

432.11 MINNESOTACARE.] (a) Effective July 1, 2004, the
432.12 diagnosis/treatment pairings described in subdivision 3 shall
432.13 not be covered under the general assistance medical care program
432.14 and under the MinnesotaCare program for persons eligible under
432.15 Minnesota Statutes, section 256L.04, subdivision 7.

432.16 (b) This subdivision expires July 1, 2007, or when a list
432.17 is established according to Minnesota Statutes, section
432.18 256B.0625, subdivision 46, whichever is earlier.

432.19 Subd. 2. [PRIOR AUTHORIZATION OF SERVICES FOR MEDICAL

432.20 ASSISTANCE.] (a) Effective July 1, 2004, prior authorization
432.21 shall be required for the diagnosis/treatment pairings described
432.22 in subdivision 3 for reimbursement under Minnesota Statutes,
432.23 chapter 256B, and under the MinnesotaCare program for persons
432.24 eligible under Minnesota Statutes, section 256L.04, subdivision
432.25 1.

432.26 (b) This subdivision expires July 1, 2007, or when a list
432.27 is established according to Minnesota Statutes, section
432.28 256B.0625, subdivision 46, whichever is earlier.

432.29 Subd. 3. [LIST OF DIAGNOSIS/TREATMENT PAIRINGS.] (a)(1)

432.30 Diagnosis: TRIGEMINAL AND OTHER NERVE DISORDERS

432.31 Treatment: MEDICAL AND SURGICAL TREATMENT

432.32 ICD-9: 350,352

432.33 (2) Diagnosis: DISRUPTIONS OF THE LIGAMENTS AND TENDONS OF

432.34 THE ARMS AND LEGS, EXCLUDING THE KNEE, GRADE II AND III

432.35 Treatment: REPAIR

432.36 ICD-9: 726.5, 727.59, 727.62-727.65, 727.68-727.69, 728.83,

433.1 728.89, 840.0-840.3, 840.5-840.9, 841-843, 845.0
433.2 (3) Diagnosis: DISORDERS OF SHOULDER
433.3 Treatment: REPAIR/RECONSTRUCTION
433.4 ICD-9: 718.01, 718.11, 718.21, 718.31, 718.41, 718.51, 718.81,
433.5 726.0, 726.10-726.11, 726.19, 726.2, 727.61, 840.4, 840.7
433.6 (4) Diagnosis: INTERNAL DERANGEMENT OF KNEE AND
433.7 LIGAMENOUS DISRUPTIONS OF THE KNEE, GRADE II AND III
433.8 Treatment: REPAIR, MEDICAL THERAPY
433.9 ICD-9: 717.0-717.4, 717.6-717.8, 718.26, 718.36, 718.46,
433.10 718.56, 727.66, 836.0-836.2, 844
433.11 (5) Diagnosis: MALUNION AND NONUNION OF FRACTURE
433.12 Treatment: SURGICAL TREATMENT
433.13 ICD-9: 733.8
433.14 (6) Diagnosis: FOREIGN BODY IN UTERUS, VULVA AND VAGINA
433.15 Treatment: MEDICAL AND SURGICAL TREATMENT
433.16 ICD-9: 939.1-939.2
433.17 (7) Diagnosis: UTERINE PROLAPSE; CYSTOCELE
433.18 Treatment: SURGICAL REPAIR
433.19 ICD-9: 618
433.20 (8) Diagnosis: OSTEOARTHRITIS AND ALLIED DISORDERS
433.21 Treatment: MEDICAL THERAPY, INJECTIONS
433.22 ICD-9: 713.5, 715, 716.0-716.1, 716.5-716.6
433.23 (9) Diagnosis: METABOLIC BONE DISEASE
433.24 Treatment: MEDICAL THERAPY
433.25 ICD-9: 731.0, 733.0
433.26 (10) Diagnosis: SYMPTOMATIC IMPACTED TEETH
433.27 Treatment: SURGERY
433.28 ICD-9: 520.6, 524.3-524.4

[...]

(b) The commissioner of human services shall identify the
455.3 related CPT codes that correspond with the diagnosis/treatment
455.4 pairings described in this section. The identification of the
455.5 related CPT codes is not subject to the requirements of
455.6 Minnesota Statutes, chapter 14.
455.7 Subd. 4. [FEDERAL APPROVAL.] The commissioner of human
455.8 services shall seek federal approval to eliminate medical
455.9 assistance coverage for the diagnosis/treatment pairings
455.10 described in subdivision 3.
455.11 Subd. 5. [NONEXPANSION OF COVERED SERVICES.] Nothing in
455.12 this section shall be construed to expand medical assistance
455.13 coverage to services that are not currently covered under the
455.14 medical assistance program as of June 30, 2004.
455.15 Sec. 49. [REPEALER.]
455.16 (a) Minnesota Statutes 2003 Supplement, sections 256.954,
455.17 subdivision 12; and 256.955, subdivision 4a, are repealed
455.18 effective July 1, 2004.
455.19 (b) Minnesota Statutes 2003 Supplement, sections 256B.0631;
455.20 and 256L.035, are repealed effective October 1, 2004.