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
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.

Sec. 9. [62J.565] [IMPLEMENTATION OF ELECTRONIC MEDICAL RECORD SYSTEM.] Subdivision 1. [GENERAL PROVISIONS.] (a) The legislature finds that there is a need to advance the use of electronic medical record systems by health care providers in the state in order to achieve significant administrative cost savings and to improve the safety, quality, and efficiency of health care delivery in the state. The legislature also finds that in order to advance the use of an electronic medical record system in a cost-effective manner and to ensure an electronic medical record system's interoperability and compatibility with other systems, the state needs to develop a standard, definitional model of an electronic medical record system that includes uniform formats, data standards, and technology standards for the collection, storage, and exchange of electronic health records. These standards must be nationally accepted, widely recognized, and available for immediate use.

(b) By January 1, 2010, all hospitals and physicians 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. (c) 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.
Subd. 2. [MODEL ELECTRONIC MEDICAL RECORD SYSTEM.] (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop a functional model for an electronic medical record system according to the following schedule:

(1) by October 1, 2005, the commissioner shall develop a model system that provides immediate, electronic on-site access to complete patient information, including information necessary for quality assurance at the point of care delivery;

(2) by October 1, 2005, the commissioner shall develop standards for secure Internet or other viewing-only access to patient medical records that require the patient to provide access information to an off-site provider and do not allow interaction with the records; and

(3) by January 15, 2006, the commissioner shall develop standards for interoperable systems for sharing and synchronizing patient data across systems. The standards must include a requirement for a secure, biometric patient identification system to ensure access security and identity authentication and shall require patient consent prior to the sharing of patient data across systems. In creating the infrastructure of the system, the model must include the development of uniform data standards in terms of clinical terminology, the exchange of data among systems, and the representation of medical information and must include the development of a common set of requirements for functional capabilities for the system software components. The uniform standards developed must be functional for use by providers of all disciplines and care settings. The standards must also be compatible with federal and private sector efforts to develop a national electronic medical record and must incorporate existing standards and state and federal regulatory requirements. In developing a model, the commissioner shall consider data privacy and security concerns and must ensure compliance with federal and state law.

(b) 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.

(c) The commissioner shall report to the legislature by January 15, 2005, on the progress in the development of uniform support.
363.35 standards and on a functional model for an electronic medical record system.

369.6 Sec. 15. [QUALITY IMPROVEMENT.]
369.7 The commissioners of human services and employee relations shall jointly develop a written plan for a provider payment system to be implemented by July 1, 2005. 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.

Sec. 25. Minnesota Statutes 2002, section 256B.0625, is amended by adding a subdivision to read:
392.17 amended by adding a subdivision to read:
392.18 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, 2005. 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:
392.22 (1) scientific and medical information;
392.24 (2) clinical assessment;
392.28 (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 professional medical associations, may designate a medical director and medical policy committee to advise the commissioner on clinical issues such as **best practice guidelines**, utilization control, and disease management and care coordination strategies. If the commissioner designates a medical director, the medical director shall be a physician who works as an employee or contractor for the Department of Human Services. If the commissioner convenes a medical policy committee, the committee shall consist of the medical director and nine members, seven of whom shall be physicians licensed to practice in Minnesota, and two of whom shall be nonphysician health professionals licensed to practice in Minnesota. Except for the medical director, the medical policy committee members shall not be employees of the Department of Human Services, shall serve three-year terms, and may be reappointed once. The commissioner shall appoint the initial members of the committee.
393.14 for terms expiring as follows: three members for terms expiring June 30, 2005, three members for terms expiring June 30, 2006, and three members for terms expiring June 30, 2007. The medical director and medical policy committee may 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, 2006, for the list effective October 1, 2006, and by October 1 of the even-numbered years thereafter. 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.

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

393.30 Subdivision 1. [GENERAL.] The commissioner shall design and implement a disease management and care coordination initiative for the medical assistance, general assistance medical care, and MinnesotaCare programs. The initiative shall provide an integrated and systematic approach to manage the health care needs of recipients who are at risk of, or diagnosed with, specified conditions or diseases that require frequent medical attention. The initiative shall seek to improve patient care and health outcomes and reduce health care costs by managing the care provided to recipients with chronic conditions.

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

(b) The commissioner shall identify the 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 2005. Based on the achievement of this goal, one-half 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 waivers or state plan amendments necessary to implement this section and to obtain federal matching funds.

Subd. 3. [MANAGED CARE CONTRACTS.] (a) 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.

(b) 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 (a) 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.

(c) 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.

Subd. 4. [HEMOPHILIA.] The commissioner shall develop a
disease management initiative for public health care program recipients who have been diagnosed with hemophilia. In developing the program, the commissioner shall explore the feasibility of contracting with a section 340B provider to provide disease management services or coordination of care in order to maximize the discounted prescription drug prices of the federal 340B program offered through section 340B of the federal Public Health Services Act, United States Code, title 42, section 256b (1999).

Sec. 46. [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 fee-for-service medical assistance program as described in Minnesota Statutes, section 256B.075, and for increasing other provider rates within the fee-for-service program.

Sec. 48. [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, 2004, the diagnosis/treatment pairings described in subdivision 3 shall not be covered under the general assistance medical care program and 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, 2004, prior authorization shall be 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.

(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.


(3) Diagnosis: DISORDERS OF SHOULDER
Treatment: REPAIR/RECONSTRUCTION
ICD-9: 718.01, 718.11, 718.21, 718.41, 718.51, 718.81,
726.0, 726.10, 726.11, 726.19, 726.2, 727.61, 840.4, 840.7.

(4) Diagnosis: INTERNAL DERANGEMENT OF KNEE AND
LIGAMENTOUS DISRUPTIONS OF THE KNEE, GRADE II AND III
Treatment: REPAIR, MEDICAL THERAPY
ICD-9: 717.0-717.4, 717.6-717.8, 718.26, 718.36, 718.46,
718.56, 727.66, 836.0-836.2, 844

(5) Diagnosis: MALUNION AND NONUNION OF FRACTURE
Treatment: SURGICAL TREATMENT
ICD-9: 733.8

(6) Diagnosis: FOREIGN BODY IN UTERUS, VULVA AND VAGINA
Treatment: MEDICAL AND SURGICAL TREATMENT
ICD-9: 939.1-939.2

(7) Diagnosis: UTERINE PROLAPSE; CYSTOCELE
Treatment: SURGICAL REPAIR
ICD-9: 618

(8) Diagnosis: OSTEOARTHRITIS AND ALLIED DISORDERS
Treatment: MEDICAL THERAPY, INJECTIONS
ICD-9: 713.5, 715, 716.0-716.1, 716.5-716.6

(9) Diagnosis: METABOLIC BONE DISEASE
Treatment: MEDICAL THERAPY
ICD-9: 731.0, 733.0

(10) Diagnosis: SYMPTOMATIC IMPACTED TEETH
Treatment: SURGERY
ICD-9: 520.6, 524.3-524.4

(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.

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, 2004.

Sec. 49. [REPEALER.]
(a) Minnesota Statutes 2003 Supplement, sections 256.954,
subdivision 12; and 256.955, subdivision 4a, are repealed
effective July 1, 2004.
(b) Minnesota Statutes 2003 Supplement, sections 256B.0631;
and 256L.035, are repealed effective October 1, 2004.