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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH
SESSION

HOUSE FILE No. **2522**

May 19, 2007

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The bill was read for the first time and referred to the Committee on Health and Human Services

A bill for an act

relating to health; guaranteeing that all necessary health care is available and affordable for every Minnesotan; establishing the Minnesota Health Care Plan; requiring a report; appropriating money; amending Minnesota Statutes 2006, sections 15.01; 15.06, subdivision 1; 15A.0815, subdivision 2; 43A.08, subdivision 1a; proposing coding for new law as Minnesota Statutes, chapter 62U.

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

ARTICLE 1

GENERAL PROVISIONS

Section 1. [62U.01] HEALTH CARE PLAN REQUIREMENTS.

In order to develop a plan that keeps Minnesotans healthy and provides the best quality of health care, the Minnesota health care plan must:

(1) ensure all Minnesotans receive high quality health care, regardless of their income;

(2) not restrict or deny care or reduce the quality of care to hold down costs, but instead reduce costs through prevention, efficiency, and reduction of bureaucracy;

(3) cover all necessary care, including all coverage currently required by law, complete mental health services, chemical dependency treatment, prescription drugs, medical equipment and supplies, dental care, long-term care, and home care services;

(4) allow patients to choose their own providers;

(5) be funded through premiums and other payments based on the person's ability to pay, so as not to deny full access to all Minnesotans;

(6) focus on preventive care and early intervention to improve the health of all Minnesotans and reduce costs from untreated illnesses and diseases;

- 2.1 (7) ensure an adequate number of qualified health care professionals and facilities to
 2.2 guarantee availability of, and timely access to quality care throughout the state;
 2.3 (8) continue Minnesota's leadership in medical education, training, research, and
 2.4 technology; and
 2.5 (9) provide adequate and timely payments to providers.

2.6 **Sec. 2. [62U.02] GENERAL PROVISIONS.**

2.7 Subdivision 1. **Short title.** Chapter 62U may be cited as the "Minnesota Health
 2.8 Care Act."

2.9 Subd. 2. **Establishment; date of operation.** The Minnesota health care plan is
 2.10 established, which shall be administered by the Minnesota Health Care Agency, an agency
 2.11 under the administration of the commissioner of health care. The Minnesota health care
 2.12 plan must be operational within two years from the date of enactment of this chapter.

2.13 Subd. 3. **Prohibition.** No health plan, as defined in section 62Q.01, subdivision
 2.14 3, except for the Minnesota health care plan, may be sold in Minnesota for services
 2.15 provided by the plan.

2.16 Subd. 4. **Purpose.** To meet the requirements in section 62U.01 This chapter shall:

2.17 (1) provide affordable coverage for all necessary health care with a single standard
 2.18 of care for all Minnesota residents;

2.19 (2) control health care costs and the growth of health care spending, subject to the
 2.20 obligation described in clause (1);

2.21 (3) achieve measurable improvement in the quality of care and the efficiency of
 2.22 care delivery;

2.23 (4) prevent disease and disability and maintain or improve health and functionality;

2.24 (5) increase health care provider, consumer, employee, and employer satisfaction
 2.25 with the health care plan; and

2.26 (6) implement policies that strengthen and improve culturally and linguistically
 2.27 competent care.

2.28 Subd. 5. **Definitions.** As used in this chapter, the following terms have the meanings
 2.29 provided:

2.30 (a) "Agency" means the Minnesota Health Care Agency.

2.31 (b) "Board" means the Health Care Policy Board.

2.32 (c) "Clinic" means an organized outpatient health facility that provides direct
 2.33 medical, surgical, dental, psychological, mental health, optometric, or podiatric advice,
 2.34 services, or treatment to patients who remain less than 24 hours, and that may also provide

3.1 diagnostic or therapeutic services to patients in the home as an alternative to care provided
3.2 at the clinic facility.

3.3 (c) "Commissioner" means the health care commissioner.

3.4 (d) "Direct care provider" means any licensed health care professional that provides
3.5 health care services through direct contact with the patient, either in person or using
3.6 approved telemedicine modalities.

3.7 (e) "Essential provider" means a health facility that has served as part of the state's
3.8 health care safety net for low income and traditionally underserved populations in
3.9 Minnesota and one that is:

3.10 (1) a "community clinic";

3.11 (2) a "free clinic";

3.12 (3) a "federally qualified health center" as defined under United States Code, title 42,
3.13 section 1395x (aa)(4) or (1396d) (1)(2);

3.14 (4) a "rural health clinic" as defined under United States Code, title 42, section
3.15 1395x (aa)(2) or 1396d (1)(1);

3.16 (5) any clinic conducted, maintained, or operated by a federally recognized Indian
3.17 tribe or tribal organization, as defined in United States Code, title 25, section 1603; or

3.18 (6) any clinic that is operated by a primary care community or free clinic and that
3.19 is operated on separate premises from the licensed clinic and is only open for limited
3.20 services of no more than 20 hours per week.

3.21 (f) "Health care provider" means any professional person, medical group,
3.22 independent practice association, organization, health facility, or other person or institution
3.23 licensed or authorized by the state to deliver or furnish health care services.

3.24 (g) "Health facility" means any facility, place, or building that is organized,
3.25 maintained, and operated for the diagnosis, care, prevention, and treatment of human
3.26 illness, physical or mental, including convalescence and rehabilitation, including care
3.27 during and after pregnancy, and including skilled nursing care and hospice.

3.28 (h) "Hospital" means all health facilities to which persons may be admitted for a
3.29 24-hour stay or longer and that are licensed under section 144.50. Hospital does not
3.30 include a nursing, skilled nursing, intermediate care, or congregate living health facility.

3.31 (i) "Integrated health care delivery system" means a provider organization that:

3.32 (1) is fully integrated operationally and clinically to provide a broad range of health
3.33 care services, including preventative care, prenatal and well-baby care, immunizations,
3.34 screening diagnostics, emergency services, hospital and medical services, surgical
3.35 services, and ancillary services;

4.1 (2) is compensated using capitation or facility budgets, for the provision of health
4.2 care services; and

4.3 (3) provides health care services primarily through direct care providers who are
4.4 either employees or partners of the organization, or through arrangements with direct
4.5 care providers or one or more groups of physicians, organized on a group practice or
4.6 individual practice basis.

4.7 (j) "Large employer" means a person, firm, proprietary or nonprofit corporation,
4.8 partnership, public agency, or association that is actively engaged in business or service,
4.9 that, on at least 50 percent of its working days during the preceding calendar year
4.10 employed at least 50 employees, or, if the employer was not in business during any part
4.11 of the preceding calendar year, employed at least 50 employees on at least 50 percent of
4.12 its working days during the preceding calendar quarter.

4.13 (k) "Primary care provider" means a direct care provider that is a family physician,
4.14 internist, general practitioner, pediatrician, obstetrician/gynecologist, or an advance
4.15 practice nurse practitioner, or physician assistant practicing under required supervision, or
4.16 essential providers who employ primary care providers.

4.17 (l) "Small employer" means a person, firm, proprietary or nonprofit corporation,
4.18 partnership, public agency, or association that is actively engaged in business or service
4.19 and that, on at least 50 percent of its working days during the preceding calendar year
4.20 employed at least two but no more than 49 employees, or, if the employer was not in
4.21 business during any part of the preceding calendar year, employed at least two but no
4.22 more than 40 eligible employees on at least 50 percent of its working days during the
4.23 preceding calendar quarter.

4.24 Subd. 6. **Transition to new plan.** (a) The transition shall be funded from a loan
4.25 from the general fund and from other sources, including private sources identified by
4.26 the commissioner.

4.27 (b) The commissioner shall assess other health plans and insurers for care provided
4.28 by the state plan in those cases in which a person's health care coverage extends into the
4.29 time period in which the new plan is operative.

4.30 (c) The commissioner shall assist persons who are displaced from employment as a
4.31 result of the initiation of the health care plan, including determining the period of time
4.32 during which assistance shall be provided and identifying sources of funds, including
4.33 dislocated worker program funds and health insurance funds, to support retraining and
4.34 job placement. That support shall be provided for a period of up to five years from the
4.35 date that this chapter becomes effective.

6.1 Sec. 3. Minnesota Statutes 2006, section 15A.0815, subdivision 2, is amended to read:

6.2 Subd. 2. **Group I salary limits.** The salaries for positions in this subdivision may
6.3 not exceed 95 percent of the salary of the governor:

6.4 Commissioner of administration;
6.5 Commissioner of agriculture;
6.6 Commissioner of education;
6.7 Commissioner of commerce;
6.8 Commissioner of corrections;
6.9 Commissioner of employee relations;
6.10 Commissioner of finance;
6.11 Commissioner of health;
6.12 Commissioner of health care;
6.13 Executive director, Minnesota Office of Higher Education;
6.14 Commissioner, Housing Finance Agency;
6.15 Commissioner of human rights;
6.16 Commissioner of human services;
6.17 Commissioner of labor and industry;
6.18 Commissioner of natural resources;
6.19 Director of Office of Strategic and Long-Range Planning;
6.20 Commissioner, Pollution Control Agency;
6.21 Commissioner of public safety;
6.22 Commissioner of revenue;
6.23 Commissioner of employment and economic development;
6.24 Commissioner of transportation; and
6.25 Commissioner of veterans affairs.

6.26 Sec. 4. Minnesota Statutes 2006, section 43A.08, subdivision 1a, is amended to read:

6.27 Subd. 1a. **Additional unclassified positions.** Appointing authorities for the
6.28 following agencies may designate additional unclassified positions according to this
6.29 subdivision: the Departments of Administration; Agriculture; Commerce; Corrections;
6.30 Education; Employee Relations; Employment and Economic Development; Explore
6.31 Minnesota Tourism; Finance; Health; Health Care Agency; Human Rights; Labor and
6.32 Industry; Natural Resources; Public Safety; Human Services; Revenue; Transportation;
6.33 and Veterans Affairs; the Housing Finance and Pollution Control Agencies; the State
6.34 Lottery; the State Board of Investment; the Office of Administrative Hearings; the Offices
6.35 of the Attorney General, Secretary of State, and State Auditor; the Minnesota State

7.1 Colleges and Universities; the Minnesota Office of Higher Education; the Perpich Center
7.2 for Arts Education; and the Minnesota Zoological Board.

7.3 A position designated by an appointing authority according to this subdivision must
7.4 meet the following standards and criteria:

7.5 (1) the designation of the position would not be contrary to other law relating
7.6 specifically to that agency;

7.7 (2) the person occupying the position would report directly to the agency head or
7.8 deputy agency head and would be designated as part of the agency head's management
7.9 team;

7.10 (3) the duties of the position would involve significant discretion and substantial
7.11 involvement in the development, interpretation, and implementation of agency policy;

7.12 (4) the duties of the position would not require primarily personnel, accounting, or
7.13 other technical expertise where continuity in the position would be important;

7.14 (5) there would be a need for the person occupying the position to be accountable to,
7.15 loyal to, and compatible with, the governor and the agency head, the employing statutory
7.16 board or commission, or the employing constitutional officer;

7.17 (6) the position would be at the level of division or bureau director or assistant
7.18 to the agency head; and

7.19 (7) the commissioner has approved the designation as being consistent with the
7.20 standards and criteria in this subdivision.

7.21 **Sec. 5. [62U.04] HEALTH CARE COMMISSIONER.**

7.22 **Subdivision 1. Commissioner.** (a) The commissioner shall be appointed by the
7.23 governor on or before January 1, 2009.

7.24 (b) The commissioner shall not have been employed in any capacity by a for-profit
7.25 insurance, pharmaceutical, or medical equipment company that sells products to the
7.26 Minnesota health care plan for a period of ten years prior to appointment as commissioner.

7.27 (c) For ten years after ending service in the Minnesota health care plan, the
7.28 commissioner may not receive payments of any kind from, or be employed in any capacity
7.29 or act as a paid consultant to, a for-profit insurance, pharmaceutical, or medical equipment
7.30 company that sells products to the Minnesota health care plan.

7.31 **Subd. 2. Duties.** (a) The commissioner shall administer all aspects of the Minnesota
7.32 Health Care Agency.

7.33 (b) The commissioner shall carry out the specific duties assigned under this chapter
7.34 and other laws related to health care, and shall enforce the execution of those provisions
7.35 and laws. The commissioner's powers and duties include, but are not limited to, the power

8.1 to establish the Minnesota health care plan budget and to set rates; to establish Minnesota
8.2 health care plan goals, standards, and priorities; to hire, fire, and fix the compensation of
8.3 agency personnel; to make allocations and reallocations to the health planning regions;
8.4 and to promulgate rules concerning matters related to the implementation of this chapter.

8.5 (c) The commissioner shall appoint the director of the fund for health care and the
8.6 director of Health Quality and Planning.

8.7 (d) The administration of the agency shall be supported from the fund for health
8.8 care created under section 62U.19.

8.9 (e) In order to avoid the appearance of political bias or impropriety, the commissioner
8.10 shall not engage in leadership of, or employment by, a political party or a political
8.11 organization; public endorsement of a political candidate; contribution of more than \$100
8.12 to any one candidate in a calendar year or contributions in excess of an aggregate of
8.13 \$1,000 in a calendar year for all political parties or organizations; and activities attempting
8.14 to avoid compliance with this paragraph by making contributions through a spouse
8.15 or other family member.

8.16 Subd. 3. **Oversight.** The commissioner shall:

8.17 (a) oversee the establishment of:

8.18 (1) the Health Care Policy Board, under section 62U.05;

8.19 (2) the Ombudsman Office of Patient Advocacy, under section 62U.09;

8.20 (3) the Office of Health Quality and Planning, under section 62U.45; and

8.21 (4) the fund for health care, under section 62U.19;

8.22 (b) determine Minnesota health care plan goals, standards, guidelines, and priorities;

8.23 (c) oversee the establishment of locally based integrated service networks that
8.24 include physicians in fee-for-service, solo and group practice, essential providers, and
8.25 ancillary care providers and facilities in order to pool and align resources and form
8.26 interdisciplinary teams that share responsibility and accountability for patient care and
8.27 provide a continuum of coordinated high-quality primary to tertiary care to all Minnesota
8.28 residents which shall be accomplished in collaboration with the director of health
8.29 planning, the regional planning boards, and the patient advocate;

8.30 (d) establish standards based on clinical efficacy to guide delivery of care;

8.31 (e) implement policies to ensure that all Minnesotans receive culturally and
8.32 linguistically competent care, according to section 62U.45, subdivision 2, and develop
8.33 mechanisms and incentives to achieve this purpose and monitor the effectiveness of
8.34 these efforts;

9.1 (f) create a systematic approach to the measurement, management, and accountability
9.2 for care quality that ensures the delivery of high-quality care to all Minnesota residents,
9.3 including a system of performance contracts that contain measurable goals and outcomes;

9.4 (g) establish a capital management framework and plan for the Minnesota health care
9.5 plan, including, but not limited to, a standardized process and format for the development
9.6 and submission of regional operating and regional capital budget requests to ensure the
9.7 needs for health care capital infrastructure are met according to the goals of the plan;

9.8 (h) ensure the establishment of policies not governed by the Department of Health
9.9 that promote public health;

9.10 (i) ensure that health care plan policies and providers support all Minnesotans in
9.11 achieving and maintaining maximum physical and mental health and functionality;

9.12 (j) establish a means to identify areas of medical practice where standards of care do
9.13 not exist and establish priorities and a timetable for their development;

9.14 (k) establish a comprehensive budget that ensures adequate funding to meet the
9.15 health care needs of the state's population and the compensation for providers for care
9.16 provided according to this chapter;

9.17 (l) establish standards and criteria for allocation of operating and capital funds from
9.18 the fund for health care as described in sections 62U.19 and 62U.35;

9.19 (m) establish standards and criteria for development and submission of provider
9.20 operating and capital budget requests;

9.21 (n) determine the level of funding to be allocated to each health care region;

9.22 (o) annually assess projected revenues and expenditures to ensure financial solvency
9.23 of the plan;

9.24 (p) during the transition and annually thereafter, determine the appropriate level for
9.25 a health care plan reserve fund and implement policies needed to establish the appropriate
9.26 reserve;

9.27 (q) institute necessary cost controls according to section 62U.19, subdivision 3,
9.28 to ensure financial solvency of the plan;

9.29 (r) develop separate formulas for budget allocations and review the formulas
9.30 annually to ensure they address disparities in service availability and health care outcomes
9.31 and for sufficiency of reimbursement;

9.32 (s) annually review the impact of the agency and its policies on the health of the
9.33 population and on satisfaction with the Minnesota health care plan;

9.34 (t) negotiate payment for any aspect of the Minnesota health care plan and establish
9.35 necessary payment procedures;

- 10.1 (u) establish a formulary based on clinical efficacy and cost for all prescription drugs
10.2 and medical equipment for use by the Minnesota health care plan;
- 10.3 (v) establish guidelines for prescribing medications, nutritional supplements, and
10.4 medical equipment that are not included in the health care formularies;
- 10.5 (w) negotiate price discounts for prescription drugs and medical equipment for use
10.6 by the Minnesota health care plan;
- 10.7 (x) create incentives and guidelines for research needed to meet health care plan
10.8 goals;
- 10.9 (y) implement eligibility standards for the system, including guidelines to prevent an
10.10 influx of persons to the state for the purpose of obtaining medical care;
- 10.11 (z) determine an appropriate level of, and provide support during the transition for,
10.12 training and job placement for persons who are displaced from employment as a result of
10.13 the initiation of the new Minnesota health care plan;
- 10.14 (aa) establish an enrollment system that ensures all eligible Minnesota residents are
10.15 aware of their right to health care and are formally enrolled;
- 10.16 (bb) oversee the establishment of the system for resolution of disputes according
10.17 to section 62U.53;
- 10.18 (cc) establish an electronic claims and payments system for the Minnesota health
10.19 care plan, to which all claims shall be filed and from which all payments shall be made,
10.20 and implement standardized claims and reporting methods;
- 10.21 (dd) establish a technology advisory committee to evaluate the cost and effectiveness
10.22 of new medical technology;
- 10.23 (ee) ensure that consumers of health care have access to information needed to
10.24 support choice of provider;
- 10.25 (ff) collaborate with the agencies that license health facilities to ensure that facility
10.26 performance is monitored and that deficient practices are recognized and corrected in a
10.27 timely fashion and that consumers and providers of health care have access to information
10.28 to support choice of facility;
- 10.29 (gg) establish a health care Web site that provides information to the public about
10.30 the Minnesota health care plan including information on providers and facilities, and that
10.31 informs the public about state and regional health care policy board meetings and activities;
- 10.32 (hh) establish a process for the system to receive the concerns, opinions, ideas, and
10.33 recommendations of the public regarding all aspects of the plan; and
- 10.34 (ii) annually report to the legislature on the performance of the Minnesota health care
10.35 plan, its fiscal condition and need for payment adjustments, recommendations for statutory
10.36 changes, receipt of payments from the federal government and other sources, whether

11.1 current year goals and priorities are met, future goals and priorities, major new technology
 11.2 or prescription drugs, and other circumstances that may affect the cost of health care.

11.3 Subd. 4. **Rulemaking.** The commissioner shall adopt rules under chapter 14 to
 11.4 implement the provisions of this chapter.

11.5 Subd. 5. **Budget preparation.** (a) The commissioner shall annually prepare a health
 11.6 care plan budget that includes all expenditures, specifies a limit on total annual state
 11.7 expenditures, and establishes allocations for each health care region that shall cover a
 11.8 three-year period and that shall be disbursed on a quarterly basis.

11.9 (b) The commissioner shall limit the growth of spending on a statewide and on a
 11.10 regional basis, by reference to average growth in state domestic product across multiple
 11.11 years, population growth, actuarial demographics and other demographic indicators,
 11.12 differences in regional costs of living, advances in technology and their anticipated
 11.13 adoption into the benefit plan, improvements in efficiency of administration and care
 11.14 delivery, improvements in the quality of care, and projected future state domestic product
 11.15 growth rates.

11.16 (c) The commissioner shall project health care plan revenues and expenditures
 11.17 for three and ten years.

11.18 (d) The commissioner shall annually convene a health care plan revenue and
 11.19 expenditure conference to discuss revenue and expenditure projections and future
 11.20 health care plan policy directions and initiatives, including means to lower the cost of
 11.21 administration, improve management of and investment in capital assets, and improve the
 11.22 quality of care and health care management.

11.23 **Sec. 6. [62U.05] HEALTH CARE POLICY BOARD.**

11.24 (a) The commissioner shall establish a health care policy board and shall serve as
 11.25 the president of the board.

11.26 (b) The board shall:

11.27 (1) establish health care plan goals and priorities, including research and capital
 11.28 investment priorities;

11.29 (2) establish the scope of services that will be funded;

11.30 (3) establish guidelines for evaluating the performance of the health care plan, health
 11.31 care plan officers, health care regions, and health care providers;

11.32 (4) establish guidelines for ensuring public input on health care plan policy,
 11.33 standards, and goals; and

11.34 (5) the Health Care Policy Board shall establish standards of care based on clinical
 11.35 efficacy for the health care plan which shall serve as guidelines to support providers in the

12.1 delivery of high-quality care. Standards shall be based on the best evidence available at
 12.2 the time and shall be continually updated. Standards are intended to support the clinical
 12.3 judgment of individual providers, not to replace it, and to support clinical decisions based
 12.4 on the needs of individual patients.

12.5 (c) The board shall consist of the following members:

12.6 (1) the commissioner;

12.7 (2) five providers appointed by the commissioner including one primary care
 12.8 physician, one registered nurse, one mental health provider, one dentist, and one long-term
 12.9 care provider;

12.10 (3) four patient advocates, two appointed by the speaker of the house and two
 12.11 appointed by the chair of the senate Committee on Rules and Administration;

12.12 (4) the director of Health Quality and Planning; and

12.13 (5) a representative from each regional planning board appointed by the regional
 12.14 board.

12.15 **Sec. 7. [62U.09] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

12.16 (a) The Ombudsman Office for Patient Advocacy is created to represent the interests
 12.17 of the consumers of health care. The goal of the ombudsman shall be to help residents
 12.18 of the state secure the health care services and benefits to which they are entitled under
 12.19 the laws administered by the department and to advocate on behalf of and represent the
 12.20 interests of consumers in governance bodies created by this chapter and in other forums.

12.21 (b) The ombudsman shall be a patient advocate appointed by the governor.

12.22 The budget for the ombudsman's office shall be determined by the legislature and is
 12.23 independent from the Health Care Agency which has no oversight or authority over the
 12.24 ombudsman for patient advocacy. The ombudsman shall establish offices throughout
 12.25 the state that shall provide convenient access to residents. The ombudsman for patient
 12.26 advocacy shall:

12.27 (1) ensure that patient advocacy services are available to all Minnesota residents;

12.28 (2) establish and maintain the grievance process according to section 62U.53;

12.29 (3) receive, evaluate, and respond to consumer complaints about the health care plan;

12.30 (4) provide a means to receive recommendations from the public about ways to
 12.31 improve the health care plan and hold public hearings at least annually to discuss problems
 12.32 and receive recommendations from the public;

12.33 (5) develop educational and informational guides according to section 15.441, for
 12.34 consumers describing consumer rights and responsibilities and inform consumers about
 12.35 the right to secure health care services and to participate in the health care plan. The

13.1 guides shall be made available to the public by the ombudsman, including access on
 13.2 the ombudsman's Web site and through public outreach and educational programs and
 13.3 displayed in provider offices and health care facilities;

13.4 (6) establish a toll-free telephone number to receive complaints regarding the health
 13.5 care plan and its services; and

13.6 (7) report annually to the public, the commissioner, and the legislature about
 13.7 the consumer perspective on the performance of the health care plan, including
 13.8 recommendations for needed improvements.

13.9 (c) The patient advocate, in carrying out assigned duties, shall have unlimited access
 13.10 to all nonconfidential and all nonprivileged documents in the custody and control of the
 13.11 Minnesota Health Care Agency.

13.12 **Sec. 8. [62U.11] INSPECTOR GENERAL FOR THE MINNESOTA HEALTH**
 13.13 **CARE PLAN.**

13.14 Subdivision 1. **Establishment.** There is within the Office of the Attorney General
 13.15 an Inspector General for the Minnesota health care plan who is appointed by the attorney
 13.16 general.

13.17 Subd. 2. **Duties.** The inspector general shall:

13.18 (1) investigate, audit, and review the financial and business records of individuals,
 13.19 public and private agencies and institutions, and private corporations that provide services
 13.20 or products to the plan, the costs of which are reimbursed by the plan;

13.21 (2) investigate allegations of misconduct on the part of an employee or appointee
 13.22 of the Minnesota Health Care Agency and on the part of any provider of health care
 13.23 services that is reimbursed by the plan, and report any findings of misconduct to the
 13.24 attorney general;

13.25 (3) investigate patterns of medical practice that may indicate fraud and abuse
 13.26 related to over or under utilization or other inappropriate utilization of medical products
 13.27 and services;

13.28 (4) arrange for the collection and analysis of data needed to investigate the
 13.29 inappropriate utilization of these products and services; and

13.30 (5) annually report recommendations for improvements to the plan to the
 13.31 commissioner.

13.32 **Sec. 9. [62U.13] TRANSITION ADVISORY GROUP; HEALTH PLANNING**
 13.33 **REGIONS.**

14.1 Subdivision 1. **Establishment.** The Health Care Policy Board shall appoint a
 14.2 transition advisory group to assist with the transition to the health care plan.

14.3 Subd. 2. **Duties.** The transition advisory group shall advise the commissioner on all
 14.4 aspects of the implementation of this chapter.

14.5 (b) The transition advisory group shall make recommendations to the commissioner
 14.6 on how the health care plan shall be regionalized for the purposes of local and
 14.7 community-based planning for the delivery of high quality, cost-effective care and
 14.8 efficient service delivery.

14.9 **Sec. 10. [62U.14] HEALTH PLANNING REGIONS.**

14.10 Subdivision 1. **Establishment.** The commissioner, in consultation with the director
 14.11 of Health Quality Planning, shall establish at least six health planning regions composed of
 14.12 geographically contiguous counties grouped on the basis of the following considerations:

- 14.13 (1) patterns of utilization of health care services;
 14.14 (2) health care resources, including workforce resources;
 14.15 (3) health needs of the population, including public health needs;
 14.16 (4) geography;
 14.17 (5) population and demographic characteristics; and
 14.18 (6) other considerations as appropriate.

14.19 Subd. 2. **Administration.** The county boards of each region shall appoint a regional
 14.20 planning director for the region. Regional planning directors shall serve at the will of the
 14.21 counties and may serve up to two four-year terms.

14.22 **Sec. 11. [62U.15] REGIONAL PLANNING.**

14.23 Subdivision 1. **Regional planning director.** (a) A regional planning director
 14.24 shall administer each health planning region. The regional planning director shall be
 14.25 responsible for all duties, the exercise of all powers and jurisdiction, and the discharge of
 14.26 all responsibilities vested by law in the regional agency.

14.27 (b) The regional planning director shall reside in the region in which the director
 14.28 serves.

14.29 (c) The regional planning director shall:

- 14.30 (1) establish and administer a regional office;
 14.31 (2) establish regional goals and priorities according to standards, goals, priorities,
 14.32 and guidelines established by the regional board;
 14.33 (3) make needed revenue-sharing arrangements so that regionalization does not limit
 14.34 a patient's choice of provider; and

15.1 (4) identify and prioritize regional health care needs and goals in collaboration with
15.2 regional health care providers and the regional planning board.

15.3 Subd. 2. **Regional planning boards.** (a) Each region shall have a regional planning
15.4 board consisting of 15 members who shall be appointed by the county boards in the
15.5 region. Members shall serve four-year terms.

15.6 (b) Regional planning board members shall have resided for a minimum of two years
15.7 in the region in which they serve prior to appointment to the board.

15.8 (c) Regional planning board members shall reside in the region they serve while
15.9 on the board.

15.10 (d) The board shall consist of the following members:

15.11 (1) the regional planning director and a public health officer from one of the regional
15.12 counties;

15.13 (2) a representative from the Ombudsman Office of Patient Advocacy;

15.14 (3) one expert in health care financing;

15.15 (4) one expert in health care planning;

15.16 (5) a registered nurse who is a direct patient care provider;

15.17 (6) a primary care physician who is a direct patient care provider;

15.18 (7) one member who represents ancillary health care workers;

15.19 (8) one member representing hospitals;

15.20 (9) one member representing essential providers;

15.21 (10) one member representing long-term care providers; and

15.22 (11) four county commissioners.

15.23 (e) The regional planning director shall serve as chair of the board.

15.24 (f) Regional planning boards shall set health policy goals for the regional planning
15.25 director on all aspects of regional health care.

15.26 **ARTICLE 3**

15.27 **FUNDING**

15.28 **Section 1. [62U.19] FUND FOR HEALTH CARE.**

15.29 Subdivision 1. **General provisions.** (a) In order to support the agency effectively in
15.30 the administration of this chapter, there is established in the state treasury the fund for
15.31 health care. The fund shall be administered by a director appointed by the commissioner.

15.32 (b) All money collected, received, and transferred according to this chapter shall be
15.33 transmitted to the state treasury to be deposited to the credit of the fund for health care for
15.34 the purpose of financing the Minnesota health care plan.

16.1 (c) Money deposited in the fund for health care shall be used exclusively to support
16.2 this chapter.

16.3 (d) All claims for health care services rendered shall be made to the fund for health
16.4 care.

16.5 (e) All payments made for health care services shall be disbursed from the fund
16.6 for health care.

16.7 Subd. 2. **Accounts.** (a) The director of the fund for health care shall establish
16.8 the following accounts within the fund:

16.9 (1) a system account to provide for all annual state expenditures for health care; and

16.10 (2) a reserve account.

16.11 (b) Premiums collected each year shall be sufficient to cover that year's projected
16.12 costs.

16.13 (c) The health care plan shall at all times hold in reserve an amount estimated in the
16.14 aggregate to provide for the payment of all losses and claims for which the plan may be
16.15 liable, and to provide for the expense of adjustment or settlement of losses and claims.

16.16 (d) During the transition, the commissioner shall work with the Department of
16.17 Commerce and other experts to determine an appropriate level of health plan reserves for
16.18 the first year and for future years of health care plan operation.

16.19 (e) Money currently held in reserve by state, city, and county health programs and
16.20 federal money for health care held in reserve in federal trust accounts shall be transferred
16.21 to the state health care reserve account when the state assumes financial responsibility for
16.22 health care under this chapter that is currently provided by those programs.

16.23 (f) The commissioner shall implement arrangements to self-insure the system
16.24 against unforeseen expenditures or revenue shortfalls not covered by plan reserves and
16.25 may borrow funds to cover temporary revenue shortfalls not covered by plan reserves,
16.26 including the issuance of bonds for this purpose, whichever is more cost-effective.

16.27 Subd. 3. **Cost control.** (a) The commissioner shall work to ensure appropriate
16.28 cost control through:

16.29 (1) aggressive public health measures, early intervention and preventive care, and
16.30 promotion of personal health improvement;

16.31 (2) changes in the delivery of health care services and administration that improve
16.32 efficiency and care quality;

16.33 (3) negotiations with providers and suppliers; and

16.34 (4) adjustments of health care provider payments to correct for deficiencies in care
16.35 quality and failure to meet compensation contract performance goals.

17.1 (b) If the commissioner determines that there will be a revenue shortfall despite the
 17.2 cost control measures in paragraph (a), the commissioner shall report to the legislature
 17.3 on the causes of the shortfall and the reasons for the failure of cost controls and shall
 17.4 recommend measures to correct the shortfall, including an increase in health care plan
 17.5 premium payments.

17.6 **Sec. 2. [62U.21] PAYMENTS.**

17.7 Subdivision 1. **Procedures.** (a) The Health Care Policy Board shall review, approve,
 17.8 reject, and modify all payment contracts and compensation plans established according
 17.9 to this section.

17.10 (b) The board shall establish and supervise a uniform payments system for providers
 17.11 and managers and shall maintain a compensation plan for the following providers and
 17.12 managers according to the provider and manager budget established by the commissioner:

17.13 (1) upper level managers including executives employed in private health care
 17.14 facilities and plans; and

17.15 (2) health care providers.

17.16 (c) Health care providers who accept any payment from the Minnesota health care
 17.17 plan for a covered service shall not bill the patient for that covered service.

17.18 (d) Health care providers may be compensated as fee-for-service providers or as
 17.19 salaried providers in the health care plan.

17.20 (e) No compensation plan or financial incentive may adversely affect the care a
 17.21 patient receives or the care a health provider recommends.

17.22 (f) Fee-for-service providers shall be paid within 30 business days for claims filed in
 17.23 compliance with procedures established by the fund for health care.

17.24 Subd. 2. **Regional payments.** (a) The commissioner shall establish an allocation for
 17.25 each region to fund regional operating and capital budgets.

17.26 (b) Integrated health care systems, essential providers, and group medical practices
 17.27 that provide comprehensive, coordinated services may choose to be reimbursed on the
 17.28 basis of a capitated system operating budget or a noncapitated system operating budget
 17.29 that covers all costs of providing health care services.

17.30 (c) Providers may include in their operating budget requests reimbursement for
 17.31 ancillary health care or social services that were previously funded by money now
 17.32 received and disbursed by the fund for health care.

17.33 (d) No payment may be made from a capitated or noncapitated budget for a capital
 17.34 expense except as stipulated in section 62U.23.

18.1 Subd. 3. **Funds from outside sources.** Facilities operating under health care plan
18.2 operating budgets may raise and expend funds from sources other than the Minnesota
18.3 health care plan including, private or foundation donors and other non-Minnesota health
18.4 care plan sources for purposes related to the goals of this section and according to the
18.5 provisions of this section.

18.6 **Sec. 3. [62U.23] CAPITAL MANAGEMENT PLAN.**

18.7 Subdivision 1. **General provisions.** (a) The commissioner shall develop a capital
18.8 management plan that shall include conflict-of-interest standards and that shall govern all
18.9 large capital investments and acquisitions undertaken in the Minnesota health care plan.
18.10 The commissioner and the regional planning directors shall issue requests for proposals
18.11 and oversee a process of competitive bidding for the development of capital projects that
18.12 meet the needs of the Minnesota health care plan and to fund, partially fund, or participate
18.13 in seeking funding for those capital projects.

18.14 (b) Providers intending to make capital investments or acquisitions shall prepare a
18.15 request including the full life-cycle costs of the project or acquisition and demonstrate
18.16 how the investment or acquisition meets the health needs of the population it is intended
18.17 to serve. Acquisitions include, but are not limited to, the acquisition of land, operational
18.18 property, or administrative office space.

18.19 (c) The commissioner shall establish standards and a process whereby the regional
18.20 planning directors shall evaluate, accept, reject, or modify a business plan for a capital
18.21 investment or acquisition. Decisions of a regional planning director may be appealed
18.22 through a dispute resolution process established by the commissioner.

18.23 Subd. 2. **Regional capital development plans.** (a) Regional planning directors
18.24 shall develop a regional capital development plan according to the Minnesota health care
18.25 plan capital management plan established by the commissioner.

18.26 (b) Services provided as a result of capital investments or acquisitions that do not
18.27 meet the terms of the regional capital development plan and the capital management plan
18.28 developed by the commissioner shall not be reimbursed by the Minnesota health care plan.

18.29 **Sec. 4. [62U.25] BUDGET.**

18.30 Subdivision 1. **Prescription drugs and durable and nondurable medical**
18.31 **equipment.** (a) The commissioner shall establish a budget for the purchase of prescription
18.32 drugs and durable and nondurable medical equipment for the health care plan.

18.33 (b) The commissioner shall negotiate the lowest possible prices for prescription
18.34 drugs and durable and nondurable medical equipment.

19.1 Subd. 2. **Research and innovation.** The commissioner shall establish a budget to
 19.2 support research and innovation that has been recommended by the Health Care Policy
 19.3 Board and the patient advocates.

19.4 Subd. 3. **Training, development, and continuing education.** (a) The commissioner
 19.5 shall establish a budget to support the training, development, and continuing education of
 19.6 health care providers and the health care workforce needed to meet the health care needs
 19.7 of the population and the goals and standards of the health care plan.

19.8 (b) During the transition, the commissioner shall determine an appropriate level and
 19.9 duration of spending to support the retraining and job placement of persons who have been
 19.10 displaced from employment as a result of the transition to the new health care plan.

19.11 Subd. 4. **Budget reserve.** The commissioner shall establish a budget reserve.
 19.12 Money in the budget reserve may be used only for the purposes specified in this chapter.

19.13 Subd. 5. **System administration.** (a) The commissioner shall establish a budget
 19.14 that covers costs of administering the Minnesota health care plan.

19.15 **Sec. 5. [62U.27] MINNESOTA HEALTH CARE PREMIUM PROPOSAL.**

19.16 Subdivision 1. **Duties.** The Minnesota Health Plan Policy Board shall:

19.17 (1) determine the aggregate costs of providing health care according to this chapter;
 19.18 and

19.19 (2) develop an equitable and affordable premium structure that is progressive and
 19.20 based on the ability to pay and that will generate adequate revenue for the fund for health
 19.21 care;

19.22 (3) in consultation with the Department of Revenue, develop an efficient means
 19.23 of collecting premiums;

19.24 (4) ensure that all income earners and all employers contribute a premium amount
 19.25 that is affordable;

19.26 (5) coordinate with existing, ongoing funding sources from federal and state
 19.27 programs; and.

19.28 (6) provide a fair distribution of monetary savings achieved from the establishment
 19.29 of the state health care plan.

19.30 Subd. 2. **Report.** On or before July 1, 2009, the board shall submit to the governor
 19.31 and the legislature a detailed recommendation for collecting the revenue to finance the
 19.32 state health care plan.

19.33 **EFFECTIVE DATE.** This section is effective the day following final enactment.

19.34 **Sec. 6. [62U.29] GOVERNMENTAL PAYMENTS.**

20.1 (a) The commissioner shall seek all necessary waivers, exemptions, agreements,
 20.2 or legislation so that all current federal payments to the state for health care are paid
 20.3 directly to the Minnesota health care plan, which shall then assume responsibility for all
 20.4 benefits and services previously paid for by the federal government with those funds. In
 20.5 obtaining the waivers, exemptions, agreements, or legislation, the commissioner shall seek
 20.6 from the federal government a contribution for health care services in Minnesota that
 20.7 shall not decrease in relation to the contribution to other states as a result of the waivers,
 20.8 exemptions, agreements, or legislation.

20.9 (b) The commissioner shall seek all necessary waivers, exemptions, agreements, or
 20.10 legislation so that all current state payments for health care are paid directly to the system,
 20.11 which shall then assume responsibility for all benefits and services previously paid for by
 20.12 state government with those funds. In obtaining the waivers, exemptions, agreements,
 20.13 or legislation, the commissioner shall seek from the legislature a contribution for health
 20.14 care services that shall not decrease in relation to state government expenditures for health
 20.15 care services in the year that this chapter was enacted, except that it may be corrected for
 20.16 change in state gross domestic product, the size and age of population, and the number of
 20.17 residents living below the federal poverty level.

20.18 **Sec. 7. [62U.31] OTHER GOVERNMENTAL PROGRAMS.**

20.19 (a) The plan's responsibility for providing care shall be secondary to existing federal,
 20.20 state, or local governmental programs for health care services to the extent that funding for
 20.21 these programs is not transferred to the fund for health care or that the transfer is delayed
 20.22 beyond the date on which initial benefits are provided under the plan.

20.23 (b) In order to minimize the administrative burden of maintaining eligibility records
 20.24 for programs transferred to the plan, the commissioner shall seek to reach an agreement
 20.25 with federal, state, and local governments in which their contributions to the fund for
 20.26 health care shall be fixed to the rate of change of the state gross domestic product, the size
 20.27 and age of population, and the number of residents living below the federal poverty level.

20.28 **Sec. 8. [62U.33] FEDERAL PREEMPTION.**

20.29 Subdivision 1. **Federal waivers.** (a) The commissioner shall pursue all reasonable
 20.30 means to secure a repeal or a waiver of any provision of federal law that preempts any
 20.31 provision of this chapter.

20.32 (b) In the event that a repeal or a waiver of law or regulations cannot be secured,
 20.33 the commissioner shall adopt rules, or seek conforming state legislation, consistent with
 20.34 federal law, in an effort to best fulfill the purposes of this chapter.

21.1 Subd. 2. **Employer contract or plan federal preemption.** (a) To the extent
 21.2 permitted by federal law, an employee entitled to health or related benefits under a contract
 21.3 or plan that, under federal law, preempts provisions of this chapter, shall first seek benefits
 21.4 under that contract or plan before receiving benefits from the plan under this chapter.

21.5 (b) No benefits shall be denied under the plan created by this chapter unless the
 21.6 employee has failed to take reasonable steps to secure like benefits from the contract or
 21.7 plan, if those benefits are available.

21.8 (c) Nothing in this chapter is intended, nor shall this chapter be construed, to
 21.9 discourage recourse to contracts or plans that are protected by federal law.

21.10 (d) To the extent permitted by federal law, a health care provider shall first seek
 21.11 payment from the contract or plan before submitting bills to the Minnesota health care
 21.12 plan.

21.13 **Sec. 9. [62U.35] SUBROGATION.**

21.14 Subdivision 1. **Collateral source.** (a) It is the intent of this chapter to establish a
 21.15 single public payer for all health care in the state of Minnesota. Until the time when the
 21.16 roles of all other payers for health care have been terminated, health care costs shall be
 21.17 collected from collateral sources whenever medical services provided to an individual
 21.18 are, or may be, covered services under a policy of insurance, health care service plan, or
 21.19 other collateral source available to that individual, or for which the individual has a right
 21.20 of action for compensation to the extent permitted by law.

21.21 (b) As used in this section, collateral source includes:

21.22 (1) insurance policies written by insurers, including the medical components of
 21.23 automobile, homeowners, and other forms of insurance;

21.24 (2) health care service plans and pension plans;

21.25 (3) employers;

21.26 (4) employee benefit contracts;

21.27 (5) government benefit programs;

21.28 (6) a judgment for damages for personal injury; and

21.29 (7) any third party who is or may be liable to an individual for health care services
 21.30 or costs.

21.31 (c) Collateral source does not include:

21.32 (1) a contract or plan that is subject to federal preemption; or

21.33 (2) any governmental unit, agency, or service, to the extent that subrogation
 21.34 is prohibited by law. An entity described in paragraph (b) is not excluded from the

22.1 obligations imposed by this section by virtue of a contract or relationship with a
22.2 governmental unit, agency, or service.

22.3 (d) The commissioner shall negotiate waivers, seek federal legislation, or make
22.4 other arrangements to incorporate collateral sources in Minnesota into the Minnesota
22.5 health care plan.

22.6 Subd. 2. **Collateral source; negotiation.** Whenever an individual receives health
22.7 care services under the plan and is entitled to coverage, reimbursement, indemnity, or
22.8 other compensation from a collateral source, the individual shall notify the health care
22.9 provider and provide information identifying the collateral source, the nature and extent
22.10 of coverage or entitlement, and other relevant information. The health care provider
22.11 shall forward this information to the commissioner. The individual entitled to coverage,
22.12 reimbursement, indemnity, or other compensation from a collateral source shall provide
22.13 additional information as requested by the commissioner.

22.14 Subd. 3. **Reimbursement.** (a) The plan shall seek reimbursement from the
22.15 collateral source for services provided to the individual and may institute appropriate
22.16 action, including legal proceedings, to recover the reimbursement. Upon demand, the
22.17 collateral source shall pay to the fund for health care the sums it would have paid or
22.18 expended on behalf of the individual for the health care services provided by the plan.

22.19 (b) In addition to any other right to recovery provided in this section, the
22.20 commissioner shall have the same right to recover the reasonable value of benefits from
22.21 a collateral source as provided to the commissioner of human services under section
22.22 256B.37.

22.23 (c) If a collateral source is exempt from subrogation or the obligation to reimburse
22.24 the plan as provided in this section, the commissioner may require that an individual who
22.25 is entitled to medical services from the source first seek those services from that source
22.26 before seeking those services from the plan.

22.27 (d) To the extent permitted by federal law, contractual retiree health benefits provided
22.28 by employers shall be subject to the same subrogation as other contracts, allowing the
22.29 Minnesota health care plan to recover the cost of services provided to individuals covered
22.30 by the retiree benefits, unless and until arrangements are made to transfer the revenues
22.31 of the benefits directly to the Minnesota health care plan.

22.32 Subd. 4. **Defaults, underpayments, and late payments.** (a) Default, underpayment,
22.33 or late payment of any tax or other obligation imposed by this chapter shall result in the
22.34 remedies and penalties provided by law, except as provided in this section.

22.35 (b) Eligibility for benefits under section 62U.37 shall not be impaired by any default,
22.36 underpayment, or late payment of any tax or other obligation imposed by this chapter.

23.1 **ARTICLE 4**
23.2 **ELIGIBILITY**

23.3 Section 1. **[62U.37] ELIGIBILITY.**

23.4 Subdivision 1. **Residency.** All Minnesota residents shall be eligible for the
23.5 Minnesota health care plan. Residency shall be based upon physical presence in the state
23.6 with the intent to reside.

23.7 Subd. 2. **Enrollment; identification.** The commissioner shall establish a procedure
23.8 to enroll eligible residents and provide each eligible individual with identification that can
23.9 be used by health care providers to determine eligibility for services.

23.10 Subd. 3. **Residents temporarily out of state.** (a) It is the intent of the legislature for
23.11 the Minnesota health care plan to provide health care coverage to Minnesota residents who
23.12 are temporarily out of the state. The commissioner shall determine eligibility standards for
23.13 residents temporarily out of state who intend to return and reside in Minnesota and for
23.14 nonresidents temporarily employed in Minnesota.

23.15 (b) Coverage for emergency care obtained out of state shall be at prevailing local
23.16 rates. Coverage for nonemergency care obtained out of state shall be according to rates and
23.17 conditions established by the commissioner. The commissioner may require that a resident
23.18 be transported back to Minnesota when prolonged treatment of an emergency condition is
23.19 necessary and when that transport will not adversely affect a patient's care or condition.

23.20 Subd. 4. **Visitors.** Visitors to Minnesota shall be billed for all services received
23.21 under the plan. The commissioner may establish intergovernmental arrangements with
23.22 other states and countries to provide reciprocal coverage for temporary visitors.

23.23 Subd. 5. **Out-of-state work.** All persons eligible for health benefits from Minnesota
23.24 employers but who are working in another jurisdiction shall be eligible for health benefits
23.25 under this chapter provided they make payments equivalent to the payments they would
23.26 be required to make if they were residing in Minnesota.

23.27 Subd. 6. **Retiree benefits.** (a) All persons who under an employer-employee
23.28 contract are eligible for retiree medical benefits, including retirees who elect to reside
23.29 outside of Minnesota, shall remain eligible for those benefits provided the contractually
23.30 mandated payments for those benefits are made to the Minnesota fund for health care,
23.31 which shall assume financial responsibility for care provided under the terms of the
23.32 contract.

23.33 (b) The commissioner may establish financial arrangements with states and foreign
23.34 countries in order to facilitate meeting the terms of the contracts described in paragraph

24.1 (a), except that payments for care provided by non-Minnesota providers to Minnesota
 24.2 retirees shall be reimbursed at rates established by the commissioner.

24.3 Subd. 7. **Minors.** Unmarried, unemancipated minors shall be deemed to have
 24.4 the residency of their parent or guardian. If a minor's parents are deceased and a legal
 24.5 guardian has not been appointed, or if a minor has been emancipated by court order, the
 24.6 minor may establish residency.

24.7 Subd. 8. **Presumptive eligibility.** (a) An individual shall be presumed to be eligible
 24.8 if the individual arrives at a health facility and is unconscious, comatose, or otherwise
 24.9 unable, because of the individual's physical or mental condition, to document eligibility or
 24.10 to act in the individual's own behalf. If the patient is a minor, the patient shall be presumed
 24.11 to be eligible, and the health facility shall provide care as if the patient were eligible.

24.12 (b) Any individual shall be presumed to be eligible when brought to a health facility
 24.13 according to any provision of section 253B.05.

24.14 (c) Any individual involuntarily committed to an acute psychiatric facility or to a
 24.15 hospital with psychiatric beds according to any provision of section 253B.05, providing
 24.16 for involuntary commitment, shall be presumed eligible.

24.17 (d) All health facilities subject to state and federal provisions governing emergency
 24.18 medical treatment shall continue to comply with those provisions.

24.19 (e) To prevent an influx of people into the state for the purposes of receiving medical
 24.20 care, the commissioner shall establish an eligibility waiting period and other criteria
 24.21 needed to protect Minnesota premium payers and ensure the fiscal stability of the health
 24.22 care plan.

24.23 **ARTICLE 5**
 24.24 **BENEFITS**

24.25 Section 1. **[62U.39] BENEFITS.**

24.26 Subdivision 1. **General provisions.** Any eligible individual may choose to receive
 24.27 services under the Minnesota health care plan from any willing professional health care
 24.28 provider participating in the plan. No health care provider may refuse to care for a
 24.29 patient solely on the basis that is specified in the definition of unfair employment practice
 24.30 contained in section 363A.08.

24.31 Subd. 2. **Covered benefits.** Covered benefits in this chapter shall include all
 24.32 medical care determined to be medically appropriate by the consumer's health care
 24.33 provider, but are subject to the limitations specified in subdivision 4. Covered benefits
 24.34 include, but are not limited to, all of the following:

24.35 (1) inpatient and outpatient health facility services;

- 25.1 (2) inpatient and outpatient professional health care provider services by licensed
25.2 health care professionals;
- 25.3 (3) diagnostic imaging, laboratory services, and other diagnostic and evaluative
25.4 services;
- 25.5 (4) durable medical equipment, appliances, and assistive technology, including
25.6 prosthetics, eyeglasses, and hearing aids and their repair;
- 25.7 (5) inpatient and outpatient rehabilitative care;
- 25.8 (6) emergency transportation and necessary transportation for health care services
25.9 for disabled and indigent persons;
- 25.10 (7) language interpretation and translation for health care services, including sign
25.11 language for those unable to speak, or hear, or who are language impaired, and Braille
25.12 translation or other services for those with no or low vision;
- 25.13 (8) child and adult immunizations and preventive care;
- 25.14 (9) health education;
- 25.15 (10) hospice care;
- 25.16 (11) home health care;
- 25.17 (12) prescription drugs that are listed on the system formulary; nonformulary
25.18 prescription drugs may be included where standards and criteria established by the
25.19 commissioner are met;
- 25.20 (13) mental and behavioral health care;
- 25.21 (14) dental care;
- 25.22 (15) podiatric care;
- 25.23 (16) chiropractic care;
- 25.24 (17) acupuncture;
- 25.25 (18) blood and blood products;
- 25.26 (19) emergency care services;
- 25.27 (20) vision care;
- 25.28 (21) adult day care;
- 25.29 (22) case management and coordination to ensure services necessary to enable a
25.30 person to remain safely in the least restrictive setting;
- 25.31 (23) substance abuse treatment;
- 25.32 (24) care in a skilled nursing facility;
- 25.33 (25) dialysis; and
- 25.34 (26) benefits offered by a bona fide church, sect, denomination, or organization
25.35 whose principles include healing entirely by prayer or spiritual means provided by a

26.1 duly authorized and accredited practitioner or nurse of that bona fide church, sect,
 26.2 denomination, or organization.

26.3 Subd. 3. **Benefit expansion.** The commissioner may expand benefits beyond the
 26.4 minimum benefits described in this section when expansion meets the intent of this chapter
 26.5 and when there are sufficient funds to cover the expansion.

26.6 Subd. 4. **Exclusions.** The following health care services shall be excluded from
 26.7 coverage by the plan:

26.8 (1) health care services determined to have no medical indication by the
 26.9 commissioner;

26.10 (2) surgery, dermatology, orthodontia, prescription drugs, and other procedures
 26.11 primarily for cosmetic purposes, unless required to correct a congenital defect, restore or
 26.12 correct a part of the body that has been altered as a result of injury, disease, or surgery,
 26.13 or determined to be medically necessary by a qualified, licensed health care provider in
 26.14 the plan;

26.15 (3) private rooms in inpatient health facilities where appropriate nonprivate rooms
 26.16 are available, unless determined to be medically necessary by a qualified, licensed health
 26.17 care provider in the plan; and

26.18 (4) services of a professional health care provider or facility that is not licensed or
 26.19 accredited by the state except for approved services provided to a Minnesota resident
 26.20 who is temporarily out of the state.

26.21 **ARTICLE 6**

26.22 **DELIVERY OF CARE**

26.23 **Section 1. [62U.41] PROVIDERS.**

26.24 (a) All health care providers licensed or accredited to practice in Minnesota may
 26.25 participate in the Minnesota health care plan.

26.26 (b) No health care provider may refuse to care for a patient on any basis that is
 26.27 specified in the definition of unfair employment practice contained in section 363A.08.

26.28 (c) All federal legislation and regulations governing referral fees and fee-splitting,
 26.29 including, but not limited to, United States Code, title 42, sections 1320a-7b and 1395nn,
 26.30 shall be applicable to all health care providers of services reimbursed under this chapter,
 26.31 whether or not the health care provider is paid with funds coming from the federal
 26.32 government.

26.33 (d) Choice of provider is subject to the following provisions.

26.34 (1) Persons eligible for health care services under this chapter may choose the
 26.35 following providers:

27.1 (i) primary care providers that include family practitioners, general practitioners,
27.2 internists and pediatricians, advance practice nurse practitioners and physician assistants
27.3 practicing under supervision as defined in section 147A.01, subdivision 18, and doctors
27.4 of osteopathy licensed to practice as general doctors; and

27.5 (ii) women may choose an obstetrician-gynecologist, in addition to a primary
27.6 provider.

27.7 (2) Persons who choose to enroll with integrated health care systems, group
27.8 medical practices, or essential providers that offer comprehensive services, shall retain
27.9 membership for at least six months after an initial three-month evaluation period during
27.10 which time they may withdraw for any reason.

27.11 (3) The three-month period shall commence on the date when an enrollee first sees
27.12 a primary care provider.

27.13 (4) Persons who want to withdraw after the initial three-month period shall request a
27.14 withdrawal according to dispute resolution procedures established by the commissioner
27.15 and may request assistance from the ombudsman for patient advocacy in the dispute
27.16 process. The dispute shall be resolved in a timely fashion and shall have no adverse
27.17 effect on the care a patient receives.

27.18 (5) Persons needing to change primary care providers because of health care needs
27.19 that their primary care provider cannot meet may change primary care providers at any
27.20 time.

27.21 **Sec. 2. [62U.43] REFERRALS.**

27.22 (a) All patients shall have a primary care provider who shall coordinate the care a
27.23 patient receives or shall ensure that a patient's care is coordinated. A specialist may serve
27.24 as the primary care provider if the patient and the provider agree to this arrangement, and
27.25 if the provider agrees to coordinate the patient's care or to ensure that the care the patient
27.26 receives is coordinated.

27.27 (b) Referrals shall be based on the medical needs of the patient and on guidelines,
27.28 which shall be established by the Health Care Policy Board.

27.29 (c) Referrals shall not be restricted or provided solely because of financial
27.30 considerations. The Health Care Policy Board shall monitor referral patterns and intervene
27.31 as necessary to ensure that referrals are neither restricted nor provided solely because of
27.32 financial considerations.

27.33 (d) The commissioner may establish or ensure the establishment of a computerized
27.34 referral registry to facilitate the referral process.

28.1 Sec. 3. **[62U.45] OFFICE OF HEALTH QUALITY AND PLANNING.**

28.2 **Subdivision 1. General provisions.** The Health Policy Board shall establish an
28.3 Office of Health Quality and Planning to provide for the short- and long-term health
28.4 needs of the population. The office shall:

28.5 (1) promote the delivery of high-quality, coordinated health care services that
28.6 enhance health; prevent illness, disease, and disability; slow the progression of chronic
28.7 diseases; and improve personal health management;

28.8 (2) establish performance criteria in measurable terms for health care goals;

28.9 (3) assist the health care regions to develop operating and capital requests according
28.10 to health care and finance guidelines established by the commissioner and this chapter. In
28.11 assisting regions, the director of the Office of Health Quality and Planning shall:

28.12 (i) identify medically undeserved areas and health service and asset shortages;

28.13 (ii) identify disparities in health outcomes;

28.14 (iii) provide information to support planning, including planning for access to
28.15 specialized centers that perform a high volume of procedures for conditions requiring
28.16 highly specialized treatments, including emergency and trauma, planning for interregional
28.17 access to needed care, and planning for coordinated interregional capital investment; and

28.18 (iv) evaluate regional budget requests and make recommendations to the
28.19 commissioner about regional revenue allocations;

28.20 (4) estimate the health care workforce required to meet the health needs of the
28.21 population, the costs of providing the needed workforce, and, in collaboration with
28.22 regional planners, educational institutions, the governor and the legislature, develop short-
28.23 and long-term plans to meet those needs, including a plan to finance needed training; and

28.24 (5) estimate the number and types of health facilities required to meet the short- and
28.25 long-term health needs of the population and the projected costs of needed facilities. In
28.26 collaboration with the commissioner, regional planning directors, the governor, and the
28.27 legislature, the director shall develop plans to finance and build needed facilities.

28.28 **Subd. 2. Culturally and linguistically competent care.** (a) The Office of Health
28.29 Quality and Planning shall establish standards for culturally and linguistically competent
28.30 care.

28.31 (b) The director of the Office of Health Quality and Planning shall annually evaluate
28.32 the effectiveness of standards for culturally and linguistically competent care and make
28.33 recommendations to the commissioner and the ombudsman for patient advocacy.

28.34 (c) The director shall pursue available federal financial participation for the provision
28.35 of a language services program that supports health care plan goals.

29.1 Subd. 3. **Health initiatives.** The Office of Health Quality and Planning shall explore
29.2 the feasibility and the value to the health of the population of the following initiatives:

29.3 (1) integrated statewide health care databases to support health care planning;

29.4 (2) electronic systems and other means that support the use of standards of care
29.5 based on clinical efficacy;

29.6 (3) development of disease management programs;

29.7 (4) electronic initiatives that lower administration costs;

29.8 (5) Web-based, patient-centered information systems that assist people to promote
29.9 and maintain health and provide information on health conditions and recent developments
29.10 in treatment; and

29.11 (6) recommend to the commissioner means to link health care research with the
29.12 goals and priorities of the health care plan.

29.13 Subd. 4. **Additional benefits.** The Office of Health Quality and Planning shall
29.14 consider additional benefits based on clinical efficacy. In considering additional benefits,
29.15 the office shall:

29.16 (1) identify safe and effective treatments;

29.17 (2) receive comments and recommendations from health care providers about
29.18 benefits that meet the needs of their patients;

29.19 (3) receive comments and recommendations made directly by patients or indirectly
29.20 through the patient advocate;

29.21 (4) identify innovative approaches to health promotion, disease and injury
29.22 prevention, education, research, and care delivery; and

29.23 (5) identify complementary and alternative modalities that have been shown by
29.24 the National Institutes of Health, Division of Complementary and Alternative Medicine
29.25 to be safe and effective.

29.26 The office shall establish pharmaceutical and medical equipment formularies based
29.27 on clinical efficacy. The formularies shall be updated regularly to reflect new drugs and
29.28 medical equipment.

29.29 (h) The office shall develop standards and criteria and a process for providers to
29.30 request authorization for services and treatments, including experimental treatments that
29.31 are not included in the plan benefit package.

29.32 (i) The office shall identify appropriate ratios of general medical providers to
29.33 specialty medical providers on a regional basis in order to meet the health care needs of
29.34 the population and the goals of the health care plan and recommend incentives and other
29.35 means to achieve recommended provider ratios.

30.1 (j) The office shall oversee coordination of the Minnesota health care plan and
 30.2 public health programs.

30.3 **Sec. 4. [62U.53] OMBUDSMAN; GRIEVANCE SYSTEM.**

30.4 Subdivision 1. **Duties of ombudsman for patient advocacy.** The ombudsman
 30.5 for patient advocacy shall establish a grievance system for all complaints. The system
 30.6 shall provide reasonable procedures that shall ensure adequate consideration of member
 30.7 grievances and appropriate remedies.

30.8 Subd. 2. **Referral of grievances.** The ombudsman for patient advocacy may
 30.9 refer any grievance that does not pertain to compliance with this chapter to the federal
 30.10 Health Care Financing Administration or any other appropriate local, state, and federal
 30.11 governmental entity for investigation and resolution.

30.12 Subd. 3. **Submittal by designated agents and providers.** A provider may join
 30.13 with, or otherwise assist, an enrollee to submit the grievance to the patient advocate
 30.14 without fear of retribution.

30.15 Subd. 4. **Review of documents.** The ombudsman may require additional
 30.16 information from providers or the commissioner.

30.17 Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice
 30.18 of the final disposition of the grievance, and the reasons for the decision, to the member, to
 30.19 any provider who is assisting the member, and to the commissioner, within 30 calendar
 30.20 days of receipt of the request for review unless the ombudsman determines that additional
 30.21 time is reasonably necessary to fully and fairly evaluate the relevant grievance. The
 30.22 ombudsman's order of corrective action shall be binding on the plan. Decisions of the
 30.23 ombudsman may only be appealed in district court.

30.24 **Sec. 5. APPROPRIATION.**

30.25 \$..... is appropriated from the general fund to the commissioner of health care for
 30.26 fiscal year 2009 to implement the provisions of this act.

30.27 **Sec. 6. EFFECTIVE DATE.**

30.28 This act is effective the day following final enactment. The commissioner of
 30.29 finance shall notify the chairs of the house of representatives and senate committees
 30.30 with jurisdiction over health care that the fund for health care has sufficient revenues to
 30.31 fund the costs of implementing this act.