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State of Minnesota
HOUSE OF REPRESENTATIVES

EIGHTY-FIFTH SESSION

HOUSE FILE NO. 1855

March 8, 2007
Authored by Huntley and Abeler
The bill was read for the first time and referred to the Committee on Health and Human Services
March 27, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Finance
May 3, 2007
Committee Recommendation and Adoption of Report:
To Pass as Amended and re-referred to the Committee on Ways and Means

A bill for an act

relating to health; requiring certain health care facilities to report on major spending commitments; requiring nonprofit hospitals and outpatient surgical centers to report on community benefits in a standard way; establishing a work group; amending Minnesota Statutes 2006, sections 62J.17, subdivisions 2, 4a, 7; 62J.41, subdivision 1; 62J.52, subdivisions 1, 2; 62J.60, subdivisions 2, 3; 144.565; 144.698, subdivision 1; repealing Minnesota Statutes 2006, section 62J.17, subdivisions 1, 5a, 6a, 8.

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

Section 1. Minnesota Statutes 2006, section 62J.17, subdivision 2, is amended to read:

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

~~(a) "Access" means the financial, temporal, and geographic availability of health care to individuals who need it.~~

~~(b)~~ (a) "Capital expenditure" means an expenditure which, under generally accepted accounting principles, is not properly chargeable as an expense of operation and maintenance.

~~(c) "Cost" means the amount paid by consumers or third party payers for health care services or products.~~

~~(d) "Date of the major spending commitment" means the date the provider formally obligated itself to the major spending commitment. The obligation may be incurred by entering into a contract, making a down payment, issuing bonds or entering a loan agreement to provide financing for the major spending commitment, or taking some other formal, tangible action evidencing the provider's intention to make the major spending commitment.~~

~~(e)~~ (b) "Health care service" means:

(1) a service or item that would be covered by the medical assistance program under chapter 256B if provided in accordance with medical assistance requirements to an eligible medical assistance recipient; and

(2) a service or item that would be covered by medical assistance except that it is characterized as experimental, cosmetic, or voluntary.

"Health care service" does not include retail, over-the-counter sales of nonprescription drugs and other retail sales of health-related products that are not generally paid for by medical assistance and other third-party coverage.

~~(f)~~ (c) "Major spending commitment" means an expenditure in excess of $1,000,000 for:

(1) acquisition of a unit of medical equipment;

(2) a capital expenditure for a single project for the purposes of providing health care services, other than for the acquisition of medical equipment;

(3) offering a new specialized service not offered before;

(4) planning for an activity that would qualify as a major spending commitment under this paragraph; or

(5) a project involving a combination of two or more of the activities in clauses (1) to (4).

The cost of acquisition of medical equipment, and the amount of a capital expenditure, is the total cost to the provider regardless of whether the cost is distributed over time through a lease arrangement or other financing or payment mechanism.

~~(g)~~ (d) "Medical equipment" means fixed and movable equipment that is used by a provider in the provision of a health care service. "Medical equipment" includes, but is not limited to, the following:

(1) an extracorporeal shock wave lithotripter;

(2) a computerized axial tomography (CAT) scanner;

(3) a magnetic resonance imaging (MRI) unit;

(4) a positron emission tomography (PET) scanner; and

(5) emergency and nonemergency medical transportation equipment and vehicles.

~~(h)~~ (e) "New specialized service" means a specialized health care procedure or treatment regimen offered by a provider that was not previously offered by the provider, including, but not limited to:

(1) cardiac catheterization services involving high-risk patients as defined in the Guidelines for Coronary Angiography established by the American Heart Association and the American College of Cardiology;

(2) heart, heart-lung, liver, kidney, bowel, or pancreas transplantation service, or any other service for transplantation of any other organ;

(3) megavoltage radiation therapy;

(4) open heart surgery;

(5) neonatal intensive care services; and

(6) any new medical technology for which premarket approval has been granted by the United States Food and Drug Administration, excluding implantable and wearable devices.

(f) "Specialty care" includes but is not limited to cardiac, neurology, orthopedic, obstetrics, mental health, chemical dependency, and emergency services.

Sec. 2. Minnesota Statutes 2006, section 62J.17, subdivision 4a, is amended to read:

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

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

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

~~(2) the date of the major spending commitment;~~

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

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

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

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

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

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

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

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

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

Each hospital, outpatient surgical center, diagnostic imaging center, and physician clinic shall report annually to the commissioner on all major spending commitments, in the form and manner specified by the commissioner. The report shall include the following information:

(a) a description of major spending commitments made during the previous year, including the total dollar amount of major spending commitments and purpose of the expenditures;

(b) the cost of land acquisition, construction of new facilities, and renovation of existing facilities;

(c) the cost of purchased or leased medical equipment, by type of equipment;

(d) expenditures by type for specialty care and new specialized services;

(e) information on the amount and types of added capacity for diagnostic imaging services, outpatient surgical services, and new specialized services; and

(f) information on investments in electronic medical records systems.

For hospitals and outpatient surgical centers, this information shall be included in reports to the commissioner that are required under section 144.698. For diagnostic imaging centers, this information shall be included in reports to the commissioner that are required under section 144.565. For physician clinics, this information shall be included in reports to the commissioner that are required under section 62J.41. For all other health care providers that are subject to this reporting requirement, reports must be submitted to the commissioner by March 1 each year for the preceding calendar year.

Sec. 3. Minnesota Statutes 2006, section 62J.17, subdivision 7, is amended to read:

Subd. 7. **Exceptions.** (a) The ~~retrospective review process as described in subdivision 5a and the prospective review and approval process as described in subdivision 6a~~ reporting requirement in subdivision 4a ~~do~~ does not apply to:

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

~~(2)~~ (1) a major spending commitment made by a research and teaching institution for purposes of conducting medical education, medical research supported or sponsored by a medical school, or by a federal or foundation grant or clinical trials;

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

~~(4)~~ (2) a major spending commitment for building maintenance including heating, water, electricity, and other maintenance-related expenditures; and

~~(5)~~ (3) a major spending commitment for activities, not directly related to the delivery of patient care services, including food service, laundry, housekeeping, and other service-related activities~~; and~~.

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

(b) In addition to the exceptions listed in paragraph (a), the ~~prospective review and approval process described in subdivision 6a~~ reporting requirement in subdivision 4a does not apply to mergers, acquisitions, and other changes in ownership or control that, in the judgment of the commissioner, do not involve a substantial expansion of service capacity or a substantial change in the nature of health care services provided.

Sec. 4. Minnesota Statutes 2006, section 62J.41, subdivision 1, is amended to read:

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

(1) the total number of patients served;

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

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

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

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

(6) total revenue by type of payer or by groups of payers, including but not limited to, revenue from Medicare, medical assistance, MinnesotaCare, nonprofit health service

plan corporations, commercial insurers, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

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

(10) revenue from donations; ~~and~~

(11) a report on health care capital expenditures during the previous year, as required by section 62J.17; and

~~(11)~~ (12) any other data required by the commissioner, including data in unaggregated form, for the purposes of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs.

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

Sec. 5. Minnesota Statutes 2006, section 62J.52, subdivision 1, is amended to read:

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

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

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

hospital-based ambulance services, and other hospital outpatient services, skilled nursing facilities, home health, freestanding renal dialysis centers, comprehensive outpatient rehabilitation facilities (CORF), outpatient rehabilitation facilities (ORF), rural health clinics, and community mental health centers; home health services such as home health intravenous therapy providers, waivered services, personal care attendants, and hospice; and any other health care provider certified by the Medicare program to use this form.

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

(e) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 6. Minnesota Statutes 2006, section 62J.52, subdivision 2, is amended to read:

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

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

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

(d) Services provided by Medicare Critical Access Hospitals electing Method II billing will be allowed an exception to this provision to allow the inclusion of the professional fees on the CMS 1450.

Sec. 7. Minnesota Statutes 2006, section 62J.60, subdivision 2, is amended to read:

Subd. 2. **General characteristics.** (a) The Minnesota uniform health care identification card must be a preprinted card constructed of plastic, paper, or any other medium that conforms with ANSI and ISO 7810 physical characteristics standards. The card dimensions must also conform to ANSI and ISO 7810 physical characteristics standard. The use of a signature panel is optional. The uniform prescription drug information contained on the card must conform with the format adopted by the NCPDP and, except as provided in subdivision 3, paragraph (a), clause (2), must include all of the fields required to submit a claim in conformance with the most recent pharmacy identification card implementation guide produced by the NCPDP. All information required to submit a prescription drug claim, exclusive of information provided on a prescription that is required by law, must be included on the card in a clear, readable, and understandable manner. If a health benefit plan requires a conditional or situational field, as defined by the NCPDP, the conditional or situational field must conform to the most recent pharmacy information card implementation guide produced by the NCPDP.

(b) The Minnesota uniform health care identification card must have an essential information window on the front side with the following data elements: card issuer name, electronic transaction routing information, card issuer identification number, cardholder (insured) identification number, and cardholder (insured) identification name. No optional data may be interspersed between these data elements.

(c) Standardized labels are required next to human readable data elements <u>and must come before the human data elements</u>.

Sec. 8. Minnesota Statutes 2006, section 62J.60, subdivision 3, is amended to read:

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

(1) card issuer name or logo, which is the name or logo that identifies the card issuer. The card issuer name or logo may be located at the top of the card. No standard label is required for this data element;

(2) complete electronic transaction routing information including, at a minimum, the international identification number. The standardized label of this data element is "RxBIN." Processor control numbers and group numbers are required if needed to electronically process a prescription drug claim. The standardized label for the process control numbers data element is "RxPCN" and the standardized label for the group numbers data element is "RxGrp," except that if the group number data element is a universal element to be used by all health care providers, the standardized label may be

"Grp." To conserve vertical space on the card, the international identification number and the processor control number may be printed on the same line;

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

(4) cardholder (insured) identification name, which is the name of the individual card holder. The identification name must be formatted as follows: first name, space, optional middle initial, space, last name, optional space and name suffix. The standardized label for this data element is "Name";

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

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

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

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

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

(2) telephone numbers and names that pharmacies and other health care providers may call for assistance. These telephone numbers and names are required on the back side of the card only if one of the contacts listed in clause (3) cannot provide pharmacies or other providers with assistance or with the telephone numbers and names of contacts for assistance; and

(3) telephone numbers and names; which are the telephone numbers and names of the following contacts with a standardized label describing the service function as applicable:

(i) eligibility and benefit information;

(ii) utilization review;

(iii) precertification; or

(iv) customer services.

(c) The following human readable data elements are mandatory on the back side of the Minnesota uniform health care identification card for health maintenance organizations:

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

(2) one of the following:

(i) telephone number to call to appeal to or file a complaint with the commissioner of health; or

(ii) for persons enrolled under section 256B.69, 256D.03, or 256L.12, the telephone number to call to file a complaint with the ombudsperson designated by the commissioner of human services under section 256B.69 and the address to appeal to the commissioner of human services. There is no standard label required for this information.

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

Sec. 9. Minnesota Statutes 2006, section 144.565, is amended to read:

144.565 DIAGNOSTIC IMAGING FACILITIES.

Subdivision 1. **Utilization and services data; economic and financial interests.** The commissioner shall require diagnostic imaging facilities and providers of diagnostic imaging services in Minnesota to ~~annually~~ report by March 1 each year for the preceding fiscal year to the commissioner, in the form and manner specified by the commissioner:

(1) utilization data for each health plan company and each public program, including workers' compensation, ~~as follows:~~ of diagnostic imaging services as defined in subdivision 4, paragraph (b);

~~(i) the number of computerized tomography (CT) procedures performed;~~

~~(ii) the number of magnetic resonance imaging (MRI) procedures performed; and~~

~~(iii) the number of positron emission tomography (PET) procedures performed; and~~

(2) the names of all physicians with any financial or economic interest and all other individuals with a ten percent or greater financial or economic interest in the facility~~.~~;

(3) the location where procedures were performed;

(4) the number of units of each type of fixed, portable, and mobile scanner used at each location;

(5) the average number of hours per month each mobile scanner was operated at each location;

(6) the number of hours per month each scanner was leased, if applicable;

(7) the total number of diagnostic imaging procedures billed for by the provider at each location, by type of diagnostic imaging service as defined in subdivision 4, paragraph (b); and

(8) a report on major health care capital expenditures during the previous year, as required by section 62J.17.

Subd. 2. **Commissioner's right to inspect records.** If the report is not filed or the commissioner of health has reason to believe the report is incomplete or false, the commissioner shall have the right to inspect diagnostic imaging facility books, audits, and records.

Subd. 3. **Separate reports.** ~~For a diagnostic imaging facility that is not attached or not contiguous to a hospital or a hospital affiliate, the commissioner shall require the information in subdivision 1 be reported separately for each detached diagnostic imaging facility as part of the report required under section 144.702.~~ If any entity owns more than one diagnostic imaging facility, that entity must report by individual facility. Reports must include only services that were billed by the provider of diagnostic imaging services submitting the report. If a diagnostic imaging facility leases capacity, technical services, or professional services to one or more other providers of diagnostic imaging services, each provider must submit a separate annual report to the commissioner for all diagnostic imaging services that it provided and billed. The owner of the leased capacity must provide a report listing the names and addresses of providers to whom the diagnostic imaging services and equipment were leased.

Subd. 4. **Definitions.** For purposes of this section, the following terms have the meanings given:

(a) "Diagnostic imaging facility" means a health care facility that ~~provides~~ is not a hospital or location licensed as a hospital which offers diagnostic imaging services ~~through the use of ionizing radiation or other imaging technique including, but not limited to magnetic resonance imaging (MRI) or computerized tomography (CT) scan on a freestanding or mobile basis~~ in Minnesota, regardless of whether the equipment used to provide the service is owned or leased. For the purposes of this section, diagnostic imaging facility includes, but is not limited to, facilities such as a physician's office, clinic, mobile transport vehicle, outpatient imaging center, or surgical center.

(b) "Diagnostic imaging service" means the use of ionizing radiation or other imaging technique on a human patient including, but not limited to, magnetic resonance imaging (MRI) or computerized tomography (CT), positron emission tomography (PET),

or single photon emission computerized tomography (SPECT) scans using fixed, portable, or mobile equipment.

~~(b)~~ (c) "Financial or economic interest" means a direct or indirect:

(1) equity or debt security issued by an entity, including, but not limited to, shares of stock in a corporation, membership in a limited liability company, beneficial interest in a trust, units or other interests in a partnership, bonds, debentures, notes or other equity interests or debt instruments, or any contractual arrangements;

(2) membership, proprietary interest, or co-ownership with an individual, group, or organization to which patients, clients, or customers are referred to; or

(3) employer-employee or independent contractor relationship, including, but not limited to, those that may occur in a limited partnership, profit-sharing arrangement, or other similar arrangement with any facility to which patients are referred, including any compensation between a facility and a health care provider, the group practice of which the provider is a member or employee or a related party with respect to any of them.

~~(c)~~ (d) "~~Freestanding~~ Fixed equipment" means a stationary diagnostic imaging ~~facility that is not located within a:~~ machine installed in a permanent location.

~~(1) hospital;~~

~~(2) location licensed as a hospital; or~~

~~(3) physician's office or clinic where the professional practice of medicine by licensed physicians is the primary purpose and not the provision of ancillary services such as diagnostic imaging.~~

~~(d)~~ (e) "Mobile equipment" means a diagnostic imaging ~~facility that is transported to various sites not including movement within a hospital or a physician's office or clinic~~ machine in a self-contained transport vehicle designed to be brought to a temporary offsite location to perform diagnostic imaging services.

(f) "Portable equipment" means a diagnostic imaging machine designed to be temporarily transported within a permanent location to perform diagnostic imaging services.

(g) "Provider of diagnostic imaging services" means a diagnostic imaging facility or an entity that offers and bills for diagnostic imaging services at a facility owned or leased by the entity.

Subd. 5. **Reports open to public inspection.** All reports filed pursuant to this section shall be open to public inspection.

Sec. 10. Minnesota Statutes 2006, section 144.698, subdivision 1, is amended to read:

Subdivision 1. **Yearly reports.** (a) Each hospital and each outpatient surgical center, which has not filed the financial information required by this section with a voluntary, nonprofit reporting organization pursuant to section 144.702, shall file annually with the commissioner of health after the close of the fiscal year:

(1) a balance sheet detailing the assets, liabilities, and net worth of the hospital or outpatient surgical center;

(2) a detailed statement of income and expenses;

(3) a copy of its most recent cost report, if any, filed pursuant to requirements of Title XVIII of the United States Social Security Act;

(4) a copy of all changes to articles of incorporation or bylaws;

(5) information on services provided to benefit the community, including services provided at no cost or for a reduced fee to patients unable to pay, teaching and research activities, or other community or charitable activities;

(6) information required on the revenue and expense report form set in effect on July 1, 1989, or as amended by the commissioner in rule;

(7) information on the number of available hospital beds that are dedicated to certain specialized services, as designated by the commissioner, and annual occupancy rates for those beds, separately for adult and pediatric care;

(8) from outpatient surgical centers, the total number of surgeries performed;

(9) a report on health care capital expenditures during the previous year, as required by section 62J.17;

~~(7)~~ (10) information on changes in ownership or control; and

~~(8)~~ (11) other information required by the commissioner in rule.

(b) Each nonprofit hospital shall report on community benefits under paragraph (a), clause (5). "Community benefit" means the costs of community care, underpayment for services provided under state health care programs, research costs, community health services costs, financial and in-kind contributions, costs of community building activities, costs of community benefit operations, education, and the cost of operating subsidized services. The cost of bad debts and underpayment for Medicare services are not included in the calculation of community benefit.

Sec. 11. **REPEALER.**

Minnesota Statutes 2006, section 62J.17, subdivisions 1, 5a, 6a, and 8, are repealed, effective the day following final enactment.

62J.17 EXPENDITURE REPORTING.

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

Subd. 5a. **Retrospective review.** (a) The commissioner shall retrospectively review each major spending commitment and notify the provider of the results of the review. The commissioner shall determine whether the major spending commitment was appropriate. In making the determination, the commissioner may consider the following criteria: the major spending commitment's impact on the cost, access, and quality of health care; the clinical effectiveness and cost-effectiveness of the major spending commitment; and the alternatives available to the provider.

(b) The commissioner may not prevent or prohibit a major spending commitment subject to retrospective review. However, if the provider fails the retrospective review, any major spending commitments by that provider for the five-year period following the commissioner's decision are subject to prospective review under subdivision 6a.

Subd. 6a. **Prospective review and approval.** (a) No health care provider subject to prospective review under this subdivision shall make a major spending commitment unless:

(1) the provider has filed an application with the commissioner to proceed with the major spending commitment and has provided all supporting documentation and evidence requested by the commissioner; and

(2) the commissioner determines, based upon this documentation and evidence, that the major spending commitment is appropriate under the criteria provided in subdivision 5a in light of the alternatives available to the provider.

(b) A provider subject to prospective review and approval shall submit an application to the commissioner before proceeding with any major spending commitment. The application must address each item listed in subdivision 4a, paragraph (a), and must also include documentation to support the response to each item. The provider may submit information, with supporting documentation, regarding why the major spending commitment should be excepted from prospective review under subdivision 7. The submission may be made either in addition to or instead of the submission of information relating to the items listed in subdivision 4a, paragraph (a).

(c) The commissioner shall determine, based upon the information submitted, whether the major spending commitment is appropriate under the criteria provided in subdivision 5a, or whether it should be excepted from prospective review under subdivision 7. In making this determination, the commissioner may also consider relevant information from other sources. At the request of the commissioner, the health technology advisory committee shall convene an expert review panel made up of persons with knowledge and expertise regarding medical equipment, specialized services, health care expenditures, and capital expenditures to review applications and make recommendations to the commissioner. The commissioner shall make a decision on the application within 60 days after an application is received.

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

Subd. 8. **Radiation therapy facilities.** This subdivision shall apply only to those major spending commitments that are related to the purchase, construction, or leasing of a radiation therapy facility.

(a) The term "provider" shall mean:

(1) a provider as defined in section 62J.03, subdivision 8;

(2) a person or organization that, upon engaging in an activity related to a major spending commitment, will become a provider as defined in section 62J.03, subdivision 8;

(3) an organization under common control with an organization described in clause (1) or (2); or

(4) an organization that manages a person or organization described in clause (1), (2), or (3).

(b) In conducting the retrospective or prospective review, the commissioner shall consider the criteria described in subdivision 5a, paragraph (a), in determining whether the major spending commitment was appropriate. In addition, the commissioner shall consider the following criteria:

(1) the alternatives available to patients in terms of avoiding an unwarranted duplication based on whether additional capacity is needed of services, facilities, or equipment in and around the location of the major spending commitment; and

(2) the best interests of the patients, including conflicts of interest that may be present in influencing the utilization of the services, facility, or equipment relating to the major spending commitment.

(c) In addition to subdivision 6a, paragraph (c), the commissioner has the authority to pursue the following remedies:

(1) assessment of fines against providers violating subdivision 6a, paragraph (a), of up to triple the amount of the major spending commitment;

(2) securing a permanent injunction against providers violating subdivision 6a, paragraph (a), halting the purchase or construction of a facility, prohibiting the operation of a facility, or the providing of a service related to the major spending commitment; and

(3) obtaining a court order to invalidate any purchase agreement, management agreement, lease, or other contract relating to the major spending commitment or the conduct of any activity relating to the major spending commitment.

(d) If a provider fails the retrospective review of a major spending commitment that is identified under this subdivision, the prospective review and approval required under subdivision 6a shall be limited to major spending commitments that are identified under this subdivision.

(e) The provisions of this subdivision do not apply to radiation therapy facilities owned and operated or managed by a hospital licensed under chapter 144.