MN Legislature Puts Bureaucrats at Bedside –

The Actual Language of the 2005 Law

Chapter 4, Minnesota Laws 2005 **(House File 139, Minnesota Legislature, Special Session 2005)**

History

Rep. Mark Olson Amendment (add expiration date to Article 8, Sec 43) fails, 7/13/05.
HF 139 passed MN House, July 13, 2005: 88-40
HF 139 passed MN Senate, July 13, 2005: 60 - 6
Signed into law by Governor Tim Pawlenty, July 14, 2005

KEY:
Bold: Titles and the words "evidence-based"
Italics: Patient privacy violations; private data on publicly-subsidized *and* privately-insured patients to be accessed by government; no patient consent

Performance Reporting on Physician Compliance with Government Treatment Directives [Article 8, Section 43, pages 373 - 375 of H.F. 139 (first and final engrossment)]:

Sec. 43. **[256B.072] [PERFORMANCE REPORTING AND QUALITY IMPROVEMENT SYSTEM.]**

(a) The commissioner of human services shall establish a performance reporting system for health care providers who provide health care services to public program recipients covered under chapters 256B, 256D, and 256L, reporting separately for managed care and fee-for-service recipients.

(b) The measures used for the performance reporting system for medical groups shall include measures of care for asthma, diabetes, hypertension, and coronary artery disease and measures of preventive care services. The measures used for the performance reporting system for inpatient hospitals shall include measures of care for acute myocardial infarction, heart failure, and pneumonia, and measures of care and prevention of surgical infections. In the case of a medical group, the measures used shall be consistent with measures published by nonprofit Minnesota or national organizations that produce and disseminate health care quality measures or **evidence-based health care guidelines.** In the case of inpatient hospital measures, the commissioner shall appoint the Minnesota Hospital Association and Stratis Health to advise on the development of the performance measures to be used for hospital reporting. To enable a consistent measurement process across the community, the commissioner may use measures of care provided for *patients in addition to those identified in paragraph (a).* The commissioner shall ensure collaboration with other health care reporting organizations so that the measures described in this section are consistent with those reported by those organizations and used by other purchasers in Minnesota.

(c) The commissioner may *require providers to submit* information in a required format to a health care reporting

organization or to cooperate with the information collection procedures of that organization. The commissioner may collaborate with a reporting organization to collect information reported and to prevent duplication of reporting.

(d) By October 1, 2007, and annually thereafter, the commissioner shall report through a public Web site the results by medical groups and hospitals, where possible, of the measures under this section, and shall compare the results by medical groups and hospitals for patients enrolled in public programs to *patients enrolled in private health plans*. To achieve this reporting, the commissioner may collaborate with a health care reporting organization that operates a Web site suitable for this purpose.

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

Required Use of "Evidence-Based Medicine" to Deny Access to Patient Care Before and During Patient Appeals Process [Article 8, Section 43, pages 415-417 of H.F. 139 (first and final engrossment)]:

Sec. 82. **[LIMITING COVERAGE OF HEALTH CARE SERVICES FOR MEDICAL ASSISTANCE, GENERAL ASSISTANCE MEDICAL CARE, AND MINNESOTACARE PROGRAMS.]**

Subdivision 1. [PRIOR AUTHORIZATION OF SERVICES.] (a) Effective September 1, 2005, prior authorization is required for the services described in subdivision 2 for reimbursement under chapters 256B, 256D, and 256L.

(b) Prior authorization shall be conducted under the direction of the medical director of the Department of Human Services in conjunction with a medical policy advisory council. To the extent available, the medical director **shall use** publicly available **evidence-based guidelines** developed by an independent, nonprofit organization or by the professional association of the specialty that typically provides the service or by a multistate Medicaid **evidence-based practice center**. If the commissioner does not have a medical director and medical policy director in place, the commissioner shall contract prior authorization to a Minnesota-licensed utilization review organization or to another entity such as a peer review organization eligible to operate in Minnesota.

(c) A prepaid health plan shall use prior authorization for the services described in subdivision 2 unless the prepaid health plan is otherwise using **evidence-based practices** to address these services.

Subd. 2. [SERVICES REQUIRING PRIOR AUTHORIZATION.] The following services require prior authorization:

(1) elective outpatient high-technology imaging to include positive emission tomography (PET) scans, magnetic resonance

imaging (MRI), computed tomography (CT), and nuclear cardiology;

(2) spinal fusion, unless in an emergency situation related to trauma;

(3) bariatric surgery;

(4) cesarean section or insertion of tympanostomy tubes except in an emergency situation;

(5) hysterectomy; and

(6) orthodontia.

Subd. 3. [RATE REDUCTION.] Effective for the services identified in subdivision 2, rendered on or after September 1, 2005, the payment rate shall be reduced by ten percent from the rate in effect on June 30, 2005. This subdivision expires July 1, 2006, or upon the completion of the prior authorization system required under subdivision 1, whichever is earlier.

Subd. 4. [APPEALS.] (a) For review of an initial determination not to certify conducted under section 62M.06, subdivision 2 or 3, of a service that is subject to prior authorization under this section, the health care provider conducting the review **must follow**, when available, published **evidence-based health care guidelines** as established by a nonprofit Minnesota quality improvement organization, a nationally recognized guideline development organization, or by the professional association of the specialty that typically provides the service.

(b) For appeals conducted under section 256.045, subdivision 3a, of a decision by a prepaid health plan to deny, reduce, or terminate a health care service that is subject to prior authorization under this section, the referee **must base** the decision on the application of the publicly available **evidence-based health care guidelines** referred to in subdivision 1 or **as established by the commissioner of human services** provided that the guidelines meet the criteria set forth in **section 62J.43, subdivision 2**.

Subd. 5. [EXPIRATION.] This section expires July 1, 2007.

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

Authors of House File 139: Reps. Fran Bradley (R-Rochester) and Tom Huntley (D-Duluth)
Authors of S.F. 107 (companion bill to HF 139): Sens. Linda Berglin (D-Minneapolis), Becky Lourey (D-Kerrick), John Hottinger (D-St. Peter), Yvonne Prettner-Solon (D-Duluth) and Paul Koering (R-Brainerd)

HHS Working Group (Legislators who approved final language):

House:
Fran Bradley (R-Rochester) – co-chair
Jim Abeler (R-Anoka)
Mary Ellen Otremba (D-Long Prairie)
Duke Powell (R-Burnsville)
Tim Wilkin (R-Eagan)

Senate:
Linda Berglin (D-Minneapolis) – co-chair
John Hottinger (D-St. Peter)
Paul Koering (R-Brainerd)
Becky Lourey (D-Kerrick)
Yvonne Prettner-Solon (D-Duluth)