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 Plan, Minnesota Health Board, Minnesota Health Fund, Office of Health Quality and Planning, ombudsman for patient advocacy, and inspector general for the Minnesota Health Plan; appropriating money; amending Minnesota Statutes 2008, sections 14.03, subdivisions 2, 3; 15A.0815, subdivision 2; proposing coding for new law as Minnesota Statutes, chapter 62V.

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

ARTICLE 1
GENERAL PROVISIONS

Section 1. **[62V.01] HEALTH PLAN REQUIREMENTS.**

In order to keep Minnesotans healthy and provide the best quality of health care, the Minnesota Health Plan must:

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

(2) not restrict, delay, 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 based on ability to pay and other revenue sources;

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

(7) ensure an adequate number of qualified health care professionals and facilities to guarantee availability of, and timely access to quality care throughout the state;

(8) continue Minnesota's leadership in medical education, training, research, and technology; and

(9) provide adequate and timely payments to providers.

Sec. 2. **[62V.02] MINNESOTA HEALTH PLAN GENERAL PROVISIONS.**

Subdivision 1. **Short title.** This chapter may be cited as the "Minnesota Health Act."

Subd. 2. **Purpose.** The Minnesota Health Plan shall provide all medically necessary health care services for all Minnesota residents in a manner that meets the requirements in section 62V.01.

Subd. 3. **Definitions.** As used in this chapter, the following terms have the meanings provided:

(a) "Board" means the Minnesota Health Board.

(b) "Plan" means the Minnesota Health Plan.

(c) "Fund" means the Minnesota Health Fund.

(d) "Medically necessary" means a health service that is consistent with the recipient's diagnosis or condition, is recognized as the prevailing standard or current practice by the provider's peer group, and is rendered to:

(1) treat an injury, illness, infection, or pain;

(2) treat a condition that could result in physical or mental disability;

(3) care for a mother and child through a maternity period;

(4) achieve a level of physical or mental function consistent with prevailing community standards for the diagnosis or condition; or

(5) provide a preventive health service.

(e) "Institutional provider" means an inpatient hospital, nursing facility, rehabilitation facility, and other health care facilities that provide overnight care.

(f) "Noninstitutional provider" means group practices, clinics, outpatient surgical centers, imaging centers, other health facilities that do not provide overnight care, and individual providers.

Subd. 4. **Ethics and conflict of interest.** (a) All provisions of section 43A.38 apply to employees and the executive officer of the Minnesota Health Plan, the members and directors of the Minnesota Health Board, the regional health boards, the director of the Office of Health Quality and Planning, the director of the Minnesota Health Fund, and the ombudsman. Failure to comply with section 43A.38 shall be grounds for disciplinary action including termination of employment or removal from the board.

(b) In order to avoid the appearance of political bias or impropriety, the Minnesota Health Plan executive officer shall not:

(1) engage in leadership of, or employment by, a political party or a political organization;

(2) publicly endorse a political candidate;

(3) contribute to any political candidates or political parties and political organizations; or

(4) attempt to avoid compliance with this subdivision by making contributions through a spouse or other family member.

(c) In order to avoid a conflict of interest, individuals specified in paragraph (a) shall not be currently employed by a medical provider or a pharmaceutical, medical insurance, or medical supply company. This paragraph does not apply to the five provider members of the board.

Subd. 5. **Data practice.** Notwithstanding chapter 13, other state agencies shall cooperate with data sharing and provide all requested information to the board or board designee, the Ombudsman for Patient Advocacy, the director of the Office of Health Quality and Planning, and the Inspector General.

Sec. 3. Minnesota Statutes 2008, section 14.03, subdivision 3, is amended to read:

Subd. 3. **Rulemaking procedures.** (a) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules concerning only the internal management of the agency or other agencies that do not directly affect the rights of or procedures available to the public;

(2) an application deadline on a form; and the remainder of a form and instructions for use of the form to the extent that they do not impose substantive requirements other than requirements contained in statute or rule;

(3) the curriculum adopted by an agency to implement a statute or rule permitting or mandating minimum educational requirements for persons regulated by an agency, provided the topic areas to be covered by the minimum educational requirements are specified in statute or rule;

(4) procedures for sharing data among government agencies, provided these procedures are consistent with chapter 13 and other law governing data practices.

(b) The definition of a rule in section 14.02, subdivision 4, does not include:

(1) rules of the commissioner of corrections relating to the release, placement, term, and supervision of inmates serving a supervised release or conditional release term, the

internal management of institutions under the commissioner's control, and rules adopted under section 609.105 governing the inmates of those institutions;

(2) rules relating to weight limitations on the use of highways when the substance of the rules is indicated to the public by means of signs;

(3) opinions of the attorney general;

(4) the data element dictionary and the annual data acquisition calendar of the Department of Education to the extent provided by section 125B.07;

(5) the occupational safety and health standards provided in section 182.655;

(6) revenue notices and tax information bulletins of the commissioner of revenue;

(7) uniform conveyancing forms adopted by the commissioner of commerce under section 507.09;

(8) standards adopted by the Electronic Real Estate Recording Commission established under section 507.0945; ~~or~~

(9) the interpretive guidelines developed by the commissioner of human services to the extent provided in chapter 245A~~.~~; or

(10) any schedules or provisions for payment under section 62V.05.

ARTICLE 2
ELIGIBILITY

Section 1. **[62V.03] ELIGIBILITY.**

Subdivision 1. **Residency.** All Minnesota residents are eligible for the Minnesota Health Plan. The board shall establish standards to prevent people from moving to the state for the purpose of obtaining medical care.

Subd. 2. **Enrollment; identification.** The Minnesota Health Board shall establish a procedure to enroll residents and provide each with identification that may be used by health care providers to confirm eligibility for services. The application for enrollment shall be no more than two pages.

Subd. 3. **Residents temporarily out of state.** (a) The Minnesota Health Plan shall provide health care coverage to Minnesota residents who are temporarily out of the state who intend to return and reside in Minnesota.

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

Subd. 4. **Visitors.** Nonresidents visiting Minnesota shall be billed for all services received under the Minnesota Health Plan. The board may enter into intergovernmental arrangements or contracts with other states and countries to provide reciprocal coverage for temporary visitors.

Subd. 5. **Nonresident employed in Minnesota.** The board may extend eligibility to nonresidents employed in Minnesota using a sliding premium scale.

Subd. 6. **Retiree benefits.** (a) All persons who are eligible for retiree medical benefits under an employer-employee contract shall remain eligible for those benefits provided the contractually mandated payments for those benefits are made to the Minnesota Health Fund, which shall assume financial responsibility for care provided under the terms of the contract along with additional health benefits covered by the Minnesota Health Plan. Retirees who elect to reside outside of Minnesota shall be eligible for benefits under the terms and conditions of the retiree's employer-employee contract.

(b) The board may establish financial arrangements with states and foreign countries in order to facilitate meeting the terms of the contracts described in paragraph (a). Payments for care provided by non-Minnesota providers to Minnesota retirees shall be reimbursed at rates established by the Minnesota Health Board.

Subd. 7. **Presumptive eligibility.** (a) An individual is presumed eligible for coverage under the Minnesota Health Plan if the individual arrives at a health facility unconscious, comatose, or otherwise unable, because of the individual's physical or mental condition, to document eligibility or to act on the individual's own behalf. If the patient is a minor, the patient is presumed eligible, and the health facility shall provide care as if the patient were eligible.

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

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

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

ARTICLE 3
BENEFITS

Section 1. **[62V.04] BENEFITS.**

Subdivision 1. **General provisions.** Any eligible individual may choose to receive services under the Minnesota Health Plan from any licensed participating provider. A

provider may not refuse to care for a patient on the basis that is specified in the definition of unfair employment practice in section 363A.08.

Subd. 2. **Covered benefits.** Covered benefits in this chapter include all medically necessary care subject to the limitations specified in subdivision 4. Covered benefits include:

(1) inpatient and outpatient health facility services;

(2) inpatient and outpatient professional health care provider services by licensed health care professionals;

(3) diagnostic imaging, laboratory services, and other diagnostic and evaluative services;

(4) medical equipment, appliances, and assistive technology, including prosthetics, eyeglasses, and hearing aids and their repair;

(5) inpatient and outpatient rehabilitative care;

(6) emergency transportation;

(7) necessary transportation for health care services for disabled and indigent persons;

(8) language interpretation and translation for health care services, including sign language and Braille or other services needed for individuals with communication disabilities;

(9) child and adult immunizations and preventive care;

(10) health education;

(11) hospice care;

(12) home health care;

(13) all prescription drugs on the Minnesota Health Plan formulary and additional drugs as specified by the board;

(14) all prescription drugs as determined by the board if the Minnesota Health Plan does not have a prescription drug formulary;

(15) mental health services;

(16) dental care;

(17) podiatric care;

(18) chiropractic care;

(19) acupuncture;

(20) blood and blood products;

(21) emergency care services;

(22) vision care;

(23) adult day care;

(24) case management and coordination to ensure services necessary to enable a person to remain safely in the least restrictive setting;

(25) substance abuse treatment;

(26) care in a skilled nursing facility; and

(27) dialysis.

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

Subd. 4. **Exclusions.** The following health care services shall be excluded from coverage by the Minnesota Health Plan:

(1) health care services determined to have no medical benefit by the board;

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

(3) private rooms in inpatient health facilities where appropriate nonprivate rooms are available, unless determined to be medically necessary by a qualified, licensed provider in the Minnesota Health Plan; and

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

Subd. 5. **Prohibition.** The Minnesota Health Plan shall not pay for prescription drugs from pharmaceutical companies that directly market the drugs to consumers.

Sec. 2. **[62V.041] CARE COORDINATION.**

(a) All patients shall have a primary care provider that may include registered nurses, physician assistants, or other providers who shall coordinate the care a patient receives. A specialist may serve as the care coordinator if the patient and the specialist agree to this arrangement, and if the specialist agrees to coordinate the patient's care.

(b) Referrals are not required for a patient to see a health care specialist. If a patient sees a specialist and does not have a care coordinator, the patient must choose a care coordinator. The Minnesota Health Plan may assist with choosing a primary care provider to coordinate care.

(c) The board may establish or ensure the establishment of a computerized referral registry to facilitate referrals.

ARTICLE 4
FUNDING

Section 1. **[62V.19] MINNESOTA HEALTH FUND.**

Subdivision 1. **General provisions.** (a) The board shall establish a Minnesota Health Fund to implement the Minnesota Health Plan and to receive premiums and other sources of revenue. The fund shall be administered by a director appointed by the Minnesota Health Board.

(b) All money collected, received, and transferred according to this chapter shall be deposited in the Minnesota Health Fund for the purpose of financing the Minnesota Health Plan.

(c) Money deposited in the Minnesota Health Fund shall be used exclusively to implement the purpose of this chapter.

(d) All claims for health care services rendered shall be made to the Minnesota Health Fund.

(e) All payments made for health care services shall be disbursed from the Minnesota Health Fund.

(f) Premiums and other revenues collected each year must be sufficient to cover that year's projected costs.

Subd. 2. **Accounts.** The Minnesota Health Fund shall have operating, capital, and reserve accounts to provide for all state expenditures for health care.

Subd. 3. **Budgets within the operating account.** The operating account in the Minnesota Health Fund shall be comprised of the accounts and budgets specified in paragraphs (a) to (e).

(a) **Medical services budget and account.** The medical services budget and account must be used to provide for all medical services and benefits covered under the Minnesota Health Plan.

(b) **Prevention budget and account.** The prevention budget and account must be used solely to establish and maintain primary community prevention programs, including preventive screening tests.

(c) **Program administration, evaluation, planning, and assessment budget and account.** The program administration, evaluation, planning, and assessment budget and account must be used to monitor and improve the plan's effectiveness and operations. The board may establish grant programs including demonstration projects for this purpose.

(d) **Training, development, and continuing education budget and account.** The training, development, and continuing education budget and account must be used to

support the training, development, and continuing education of health care providers and the health care workforce needed to meet the health care needs of the population.

(e) **Medical research budget and account.** The medical research budget and account must be used to support research and innovation as determined by the Minnesota Health Board, and recommended by the Office of Health Quality and Planning and the Ombudsman for Patient Advocacy.

Subd. 4. **Capital account.** The capital account must be used solely to pay for capital expenditures for institutional providers and all capital expenditures requiring approval from the Minnesota Health Board as specified in section 62V.05, subdivision 4.

Subd. 5. **Reserve account.** (a) The Minnesota Health Plan must at all times hold in reserve an amount estimated in the aggregate to provide for the payment of all losses and claims for which the Minnesota Health Plan may be liable and to provide for the expense of adjustment or settlement of losses and claims.

(b) Money currently held in reserve by state, city, and county health programs must be transferred to the Minnesota Health Fund when the Minnesota Health Plan replaces those programs.

(c) The board shall have provisions in place to insure the Minnesota Health Plan against unforeseen expenditures or revenue shortfalls not covered by the reserve account and the board may borrow money to cover temporary shortfalls.

Sec. 2. **[62V.20] REVENUE SOURCES.**

Subdivision 1. **Minnesota Health Plan premium.** (a) The Minnesota Health Board shall:

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

(2) develop an equitable and affordable premium structure, including unearned income as part of the premium determination for Minnesota residents, that is progressive and based on the ability to pay and a business health tax for businesses that together will generate adequate revenue for the Minnesota Health Fund;

(3) develop a premium structure for individuals that has an appropriate range based on an individual's ability to pay and includes a cap on the maximum premium any individual pays;

(4) in consultation with the Department of Revenue, develop an efficient means of collecting premiums and the business health tax; and

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

(b) On or before January 15, 2010, the board shall submit to the governor and the legislature a report on the premium and business health tax structure established to finance the Minnesota Health Plan.

Subd. 2. **Funds from outside sources.** Institutional providers operating under Minnesota Health Plan operating budgets may raise and expend funds from sources other than the Minnesota Health Plan including private or foundation donors. Contributions to providers in excess of $500,000 must be reported to the board.

Subd. 3. **Governmental payments.** The executive officer and, if required under federal law, the commissioners of health and human services shall seek all necessary waivers, exemptions, agreements, or legislation so that all current federal payments to the state for health care are paid directly to the Minnesota Health Plan, which shall then assume responsibility for all benefits and services previously paid for by the federal government with those funds. In obtaining the waivers, exemptions, agreements, or legislation, the executive officer and, if required, commissioners shall seek from the federal government a contribution for health care services in Minnesota that reflects: medical inflation, the state gross domestic product, the size and age of the population, the number of residents living below the poverty level, and the number of Medicare and VA eligible individuals, and does not decrease in relation to the federal contribution to other states as a result of the waivers, exemptions, agreements, or savings from implementation of the Minnesota Health Plan.

Subd. 4. **Federal preemption.** (a) The board shall pursue all reasonable means to secure a repeal or a waiver of any provision of federal law that preempts any provision of this chapter. The commissioners of health and human services shall provide all necessary assistance.

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

(c) The Minnesota Health Plan's responsibility for providing care shall be secondary to existing federal government programs for health care services to the extent that funding for these programs is not transferred to the Minnesota Health Fund or that the transfer is delayed beyond the date on which initial benefits are provided under the Minnesota Health Plan.

Subd. 5. **No-cost sharing.** No deductible, co-payment, coinsurance, or other cost-sharing shall be imposed with respect to covered benefits.

Sec. 3. **[62V.21] SUBROGATION.**

Subdivision 1. **Collateral source.** (a) When other payers for health care have been terminated, health care costs shall be collected from collateral sources whenever medical services provided to an individual are, or may be, covered services under a policy of insurance, or other collateral source available to that individual, or when the individual has a right of action for compensation permitted under law.

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

(1) health insurance policies and the medical components of automobile, homeowners, and other forms of insurance;

(2) medical components of worker's compensation;

(3) pension plans;

(4) employer plans;

(5) employee benefit contracts;

(6) government benefit programs;

(7) a judgment for damages for personal injury; and

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

(c) Collateral source does not include:

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

(2) any governmental unit, agency, or service, to the extent that subrogation is prohibited by law. An entity described in paragraph (b) is not excluded from the obligations imposed by this section by virtue of a contract or relationship with a government unit, agency, or service.

(d) The board shall negotiate waivers, seek federal legislation, or make other arrangements to incorporate collateral sources into the Minnesota Health Plan.

Subd. 2. **Collateral source; negotiation.** When an individual who receives health care services under the Minnesota Health Plan is entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source, the individual shall notify the health care provider and provide information identifying the collateral source, the nature and extent of coverage or entitlement, and other relevant information. The health care provider shall forward this information to the board. The individual entitled to coverage, reimbursement, indemnity, or other compensation from a collateral source shall provide additional information as requested by the board.

Subd. 3. **Reimbursement.** (a) The Minnesota Health Plan shall seek reimbursement from the collateral source for services provided to the individual and may institute appropriate action, including legal proceedings, to recover the reimbursement. Upon demand, the collateral source shall pay to the Minnesota Health Fund the sums it would

have paid or expended on behalf of the individual for the health care services provided by the Minnesota Health Plan.

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

(c) If a collateral source is exempt from subrogation or the obligation to reimburse the Minnesota Health Plan, the board may require that an individual who is entitled to medical services from the source first seek those services from that source before seeking those services from the Minnesota Health Plan.

(d) To the extent permitted by federal law, the board shall have the same right of subrogation over contractual retiree health benefits provided by employers as other contracts, allowing the Minnesota Health Plan to recover the cost of services provided to individuals covered by the retiree benefits, unless arrangements are made to transfer the revenues of the benefits directly to the Minnesota Health Plan.

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

(b) Eligibility for benefits under section 62V.04 shall not be impaired by any default, underpayment, or late payment of any premium or other obligation imposed by this chapter.

ARTICLE 5
PAYMENTS

Section 1. **[62V.05] PROVIDER PAYMENTS.**

Subdivision 1. **General provisions.** (a) All health care providers licensed to practice in Minnesota may participate in the Minnesota Health Plan.

(b) A participating health care provider shall comply with all federal laws and regulations governing referral fees and fee splitting including, but not limited to, United States Code, title 42, sections 1320a-7b and 1395nn, whether reimbursed by federal funds or not.

(c) A fee schedule or financial incentive may not adversely affect the care a patient receives or the care a health provider recommends.

Subd. 2. **Payments to noninstitutional providers.** (a) The Minnesota Health Board shall establish and oversee a uniform fee schedule for noninstitutional providers.

(b) The board shall pay noninstitutional providers based on rates negotiated with providers. Rates may factor in geographic differences to address provider shortages.

(c) The board shall examine the need for and methods of paying providers for care coordination for all patients especially those with chronic illness and complex medical needs.

(d) Providers may request reimbursement of ancillary health care or social services that were previously funded by money now received and disbursed by the Minnesota Health Fund.

(e) Providers who accept any payment from the Minnesota Health Plan for a covered service shall not bill the patient for the covered service.

(f) Providers shall be paid within 30 business days for claims filed following procedures established by the board.

Subd. 3. **Payments to institutional providers.** (a) The board shall establish annual budgets for institutional providers. These budgets shall consist of an operating and a capital budget. An institution's annual budget shall be negotiated to cover its anticipated services for the next year based on past performance and projected changes in prices and service levels.

(b) Providers who accept any payment from the Minnesota Health Plan for a covered service shall not bill the patient for the covered service.

Subd. 4. **Capital management plan.** (a) The board shall periodically develop a capital investment plan that will serve as a guide in determining the annual budgets of institutional providers and in deciding whether to approve applications for approval of capital expenditures by noninstitutional providers.

(b) Providers who propose to make capital purchases in excess of $500,000 must obtain board approval. The board may alter the threshold expenditure level that triggers the requirement to submit information on capital expenditures. Institutional providers shall propose these expenditures and submit the required information as part of the annual budget they submit to the board. Noninstitutional providers shall submit applications for approval of these expenditures to the board.

ARTICLE 6
GOVERNANCE

Section 1. Minnesota Statutes 2008, section 14.03, subdivision 2, is amended to read:

Subd. 2. **Contested case procedures.** The contested case procedures of the Administrative Procedure Act provided in sections 14.57 to 14.69 do not apply to (a) proceedings under chapter 414, except as specified in that chapter, (b) the commissioner of corrections, (c) the unemployment insurance program and the Social Security disability determination program in the Department of Employment and Economic Development,

(d) the commissioner of mediation services, (e) the Workers' Compensation Division in the Department of Labor and Industry, (f) the Workers' Compensation Court of Appeals, ~~or~~ (g) the Board of Pardons, or (h) the Minnesota Health Plan.

Sec. 2. Minnesota Statutes 2008, section 15A.0815, subdivision 2, is amended to read:

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

Commissioner of administration;

Commissioner of agriculture;

Commissioner of education;

Commissioner of commerce;

Commissioner of corrections;

Commissioner of finance;

Commissioner of health;

Executive officer of the Minnesota Health Plan;

Executive director, Minnesota Office of Higher Education;

Commissioner, Housing Finance Agency;

Commissioner of human rights;

Commissioner of human services;

Commissioner of labor and industry;

Commissioner of natural resources;

Director of Office of Strategic and Long-Range Planning;

Commissioner, Pollution Control Agency;

Executive director, Public Employees Retirement Association;

Commissioner of public safety;

Commissioner of revenue;

Executive director, State Retirement System;

Executive director, Teachers Retirement Association;

Commissioner of employment and economic development;

Commissioner of transportation; and

Commissioner of veterans affairs.

Sec. 3. **[62V.06] MINNESOTA HEALTH BOARD.**

Subdivision 1. **Establishment.** The Minnesota Health Board is established to promote the delivery of high quality, coordinated health care services that enhance health; prevent illness, disease, and disability; slow the progression of chronic diseases; and

improve personal health management. The board shall administer the Minnesota Health Plan. The board shall oversee:

(1) the Office of Health Quality and Planning under section 62V.09; and

(2) the Minnesota Health Fund under section 62V.19.

Subd. 2. **Board composition.** The board shall consist of 15 members, including a representative selected by each of the five rural regional health planning boards under section 62V.08 and three representatives selected by the metropolitan regional health planning board under section 62V.08. These members shall select the following:

(1) one consumer member and one employer member appointed by the board members; and

(2) five providers appointed by the board members that include one primary care physician, one registered nurse, one mental health provider, one dentist, and one facility director.

Subd. 3. **Term and compensation; selection of chair.** Board members shall serve four years. Board members shall set the board's compensation not to exceed the compensation of Public Utilities Commission members. The board shall select the chair from its membership.

Subd. 4. **General duties.** The board shall:

(1) ensure that all of the requirements of section 62V.01 are met;

(2) hire an executive officer for the Minnesota Health Plan to administer all aspects of the plan as directed by the board;

(3) hire a director for the Office of Health Quality and Planning;

(4) hire a director of the Minnesota Health Fund;

(5) provide technical assistance to the regional boards established under section 62V.08;

(6) conduct necessary investigations and inquiries and require the submission of information, documents, and records the board considers necessary to carry out the purposes of this chapter;

(7) establish a process for the board to receive the concerns, opinions, ideas, and recommendations of the public regarding all aspects of the Minnesota Health Plan and the means of addressing those concerns;

(8) conduct other activities the board considers necessary to carry out the purposes of this chapter;

(9) collaborate with the agencies that license health facilities to ensure that facility performance is monitored and that deficient practices are recognized and corrected in a timely manner;

(10) adopt rules as necessary to carry out the duties assigned under this chapter;

(11) establish conflict of interest standards prohibiting providers from any financial benefit from their medical decisions outside of board reimbursement;

(12) establish conflict of interest standards related to pharmaceutical marketing to providers; and

(13) create a program to provide support and retraining for workers dislocated by the creation of the Minnesota Health Plan.

The board shall ensure that workers who may be displaced because of the administrative efficiencies of the Minnesota Health Plan receive financial help and assistance in retraining and job placement. Because there is currently a serious shortage of providers in many health care professions, from medical technologists to registered nurses, and because many potentially displaced health administrative workers already have training in some medical field, the dislocated worker support program should emphasize retraining and placement into health care related positions. As Minnesota residents, all displaced workers shall be covered under the Minnesota Health Plan.

Subd. 5. **Conflict of interest committee.** (a) The board shall establish a conflict of interest committee to develop standards of practice for individuals or entities doing business with the Minnesota Health Plan, including but not limited to, board members, providers, and medical suppliers. The committee shall establish guidelines on the duty to disclose the existence of a financial interest and all material facts related to that financial interest to the committee.

(b) In considering the transaction or arrangement, if the committee determines a conflict of interest exists, the committee shall investigate alternatives to the proposed transaction or arrangement. After exercising due diligence, the committee shall determine whether the Minnesota Health Plan can obtain with reasonable efforts a more advantageous transaction or arrangement with a person or entity that would not give rise to a conflict of interest. If this is not reasonably possible under the circumstances, the committee shall make a recommendation to the board on whether the transaction or arrangement is in the best interest to the operation of the Minnesota Health Plan for the benefit of the plan, and whether the transaction is fair and reasonable. The committee shall provide the board with all material information used to make the recommendation. After reviewing all relevant information, the board shall decide whether to approve the transaction or arrangement.

Subd. 6. **Financial duties.** The board shall:

(1) establish and collect premiums and the business health tax according to section 62V.20, subdivision 1;

(2) approve statewide and regional budgets that include budgets for the accounts in section 62V.19;

(3) establish payment rates for providers which may reflect regional differences to address provider shortages;

(4) monitor compliance with all budgets and payment rates and take action to achieve compliance to the extent authorized by law;

(5) pay claims for medical products or services as negotiated, and may issue requests for proposals for a contract to process claims submitted by individual nonprofit providers;

(6) negotiate fees, prices, and budgets;

(7) administer the Minnesota Health Fund created under section 62V.19;

(8) annually determine the appropriate level for the Minnesota Health Plan reserve account and implement policies needed to establish the appropriate reserve;

(9) implement fraud prevention measures necessary to protect the operation of the Minnesota Health Plan; and

(10) work to ensure appropriate cost control by:

(i) instituting aggressive public health measures, early intervention and preventive care, and promotion of personal health improvement;

(ii) making changes in the delivery of health care services and administration that improve efficiency and care quality;

(iii) minimizing administrative costs;

(iv) ensuring that the delivery system does not contain excess capacity; and

(v) negotiating the lowest possible prices for prescription drugs, medical equipment, and medical services.

If the board determines that there will be a revenue shortfall despite the cost control measures mentioned in clause (10), the board shall implement measures to correct the shortfall, including an increase in premiums. The board shall report to the legislature on the causes of the shortfall, reasons for the failure of cost controls, and measures taken to correct the shortfall.

Subd. 7. **Minnesota Health Board management duties.** The board shall:

(1) develop and implement enrollment procedures for providers and persons eligible for the program and disseminate, to providers of services and to the public, information concerning the program and the persons eligible to receive benefits under the program;

(2) implement eligibility standards for the Minnesota Health Plan, including standards to prevent people moving to the state for the purpose of obtaining medical care;

(3) make recommendations, when needed, to the legislature about changes in the geographic boundaries of the health planning regions;

(4) establish an electronic claims and payments system for the Minnesota Health Plan;

(5) monitor the operation of the Minnesota Health Plan through consumer surveys and regular data collection and evaluation activities, including evaluations of the adequacy and quality of services furnished under the program, the need for changes in the benefit package, the cost of each type of service, and the effectiveness of cost control measures under the program;

(6) establish a health care Web site that provides information to the public about the Minnesota Health Plan including access information on providers and facilities, and that informs the public about state and regional health planning board meetings and activities;

(7) collaborate with public health agencies, schools, and community clinics;

(8) ensure that Minnesota Health Plan policies and providers, including public health providers, support all Minnesota residents in achieving and maintaining maximum physical and mental health functionality; and

(9) annually report to the legislature on the performance of the Minnesota Health Plan, fiscal condition and need for payment adjustments, any needed changes in geographic boundaries of the health planning regions, recommendations for statutory changes, receipt of revenue from all sources, whether current year goals and priorities are met, future goals and priorities, major new technology or prescription drugs, and other circumstances that may affect the cost of health care.

Subd. 8. **Policy duties.** The board shall:

(1) develop and implement cost control and quality assurance procedures, including a professional peer review system;

(2) ensure strong public health services including education and community prevention and clinical services;

(3) ensure a continuum of coordinated high-quality primary to tertiary care to all Minnesota residents; and

(4) implement policies to ensure that all Minnesotans receive culturally and linguistically competent care.

Sec. 4. **[62V.07] HEALTH PLANNING REGIONS.**

A metropolitan health planning region consisting of the seven-county metropolitan area is established. By October 1, 2009, the commissioner of health shall designate five rural health planning regions from the greater Minnesota area composed of geographically contiguous counties grouped on the basis of the following considerations:

(1) patterns of utilization of health care services;

(2) health care resources, including workforce resources;

(3) health needs of the population, including public health needs;

(4) geography;

(5) population and demographic characteristics; and

(6) other considerations as appropriate.

The commissioner of health shall designate the health planning regions.

Sec. 5. **[62V.08] REGIONAL HEALTH PLANNING BOARD.**

Subdivision 1. **Regional planning board composition.** (a) Initially, each regional board shall consist of one county commissioner per county selected by the county board and two county commissioners per county selected by the county board in the seven-county metropolitan area. A county commissioner may designate a representative to act as a member of the board in the member's absence. Each board shall select the chair from among its membership.

(b) Board members shall serve for four-year terms and may receive per diems for meetings as provided in section 15.059, subdivision 3.

Subd. 2. **Regional health board duties.** Regional health planning boards shall:

(1) recommend health standards, goals, priorities, and guidelines for the region;

(2) prepare an operating and capital budget for the region to recommend to the Minnesota Health Board;

(3) collaborate with local public health care agencies to educate consumers and providers on public health programs, goals, and the means of reaching those goals;

(4) hire a regional health planning director;

(5) collaborate with public health care agencies to implement public health and wellness initiatives; and

(6) ensure that all parts of the region have access to a 24-hour nurse hotline and 24-hour urgent care clinics.

Sec. 6. **[62V.09] OFFICE OF HEALTH QUALITY AND PLANNING.**

Subdivision 1. **Establishment.** The Minnesota Health Board shall establish an Office of Health Quality and Planning to assess the quality, access, and funding adequacy of the Minnesota Health Plan.

Subd. 2. **General duties.** (a) The Office of Health Quality and Planning shall make annual recommendations to the board on the overall direction on subjects including:

(1) the overall effectiveness of the Minnesota Health Plan in addressing public health and wellness;

(2) access to care;

(3) quality improvement;

(4) efficiency of administration;

(5) adequacy of budget and funding;

(6) appropriateness of payments for providers;

(7) capital expenditure needs;

(8) long-term care;

(9) mental health and substance abuse services;

(10) staffing levels and working conditions in health care facilities;

(11) identification of number and mix of health care facilities and providers required to best meet the needs of the Minnesota Health Plan;

(12) care for chronically ill patients;

(13) research needs; and

(14) integration of disease management programs into care delivery.

(b) Analyze shortages in health care workforce required to meet the needs of the population and develop plans to meet those needs in collaboration with regional planners and educational institutions.

(c) Assist in coordination of the Minnesota Health Plan and public health programs.

Subd. 3. **Assessment and evaluation of benefits.** The Office of Health Quality and Planning shall:

(1) consider benefit additions to the Minnesota Health Plan and evaluate them based on evidence of clinical efficacy;

(2) establish a process and criteria by which providers may request authorization to provide services and treatments that are not included in the Minnesota Health Plan benefit set, including experimental treatments;

(3) evaluate proposals to increase the efficiency and effectiveness of the health care delivery system, and make recommendations to the board based on the cost-effectiveness of the proposals; and

(4) identify complementary and alternative modalities that have been shown to be safe and effective.

Sec. 7. **[62V.10] OMBUDSMAN OFFICE FOR PATIENT ADVOCACY.**

Subdivision 1. **Creation of office; generally.** (a) The Ombudsman Office for Patient Advocacy is created to represent the interests of the consumers of health care. The ombudsman shall help residents of the state secure the health care services and benefits they are entitled to under the laws administered by the Minnesota Health Board

and advocate on behalf of and represent the interests of enrollees in entities created by this chapter and in other forums.

(b) The ombudsman shall be a patient advocate appointed by the governor, who serves in the unclassified service and may be removed only for just cause. The ombudsman must be selected without regard to political affiliation and must be knowledgable about and have experience in health care services and administration.

(c) The ombudsman may gather information about decisions, acts, and other matters of the Minnesota Health Board, health care organization, or a health care program. A person may not serve as ombudsman while holding another public office.

(d) The budget for the ombudsman's office shall be determined by the legislature and is independent from the Minnesota Health Board which has no oversight or authority over the ombudsman for patient advocacy. The ombudsman shall establish offices to provide convenient access to residents.

Subd. 2. **Ombudsman's duties.** (a) The ombudsman for patient advocacy shall:

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

(2) establish and maintain the grievance process according to section 62V.11;

(3) receive, evaluate, and respond to consumer complaints about the Minnesota Health Plan;

(4) establish a process to receive recommendations from the public about ways to improve the Minnesota Health Plan;

(5) develop educational and informational guides according to communication services under section 15.441, describing consumer rights and responsibilities;

(6) ensure the guides in clause (5) are widely available to consumers and specifically available in provider offices and health care facilities; and

(7) report annually to the public, the board, and the legislature about the consumer perspective on the performance of the Minnesota Health Plan, including recommendations for needed improvements.

(b) The patient advocate, in carrying out assigned duties, shall have unlimited access to all nonconfidential and all nonprivileged documents in the custody and control of the Minnesota Health Board.

Sec. 8. **[62V.11] GRIEVANCE SYSTEM.**

Subdivision 1. **Grievance system established.** The ombudsman for patient advocacy shall establish a grievance system for all complaints. The system shall provide reasonable procedures that shall ensure adequate consideration of Minnesota Health Plan enrollee grievances and appropriate remedies.

Subd. 2. **Referral of grievances.** The ombudsman for patient advocacy may refer any grievance that does not pertain to compliance with this chapter to the federal Center for Medicaid or any other appropriate local, state, and federal government entity for investigation and resolution.

Subd. 3. **Submittal by designated agents and providers.** A provider may join with, or otherwise assist, a complainant to submit the grievance to the ombudsman without fear of retribution.

Subd. 4. **Review of documents.** The ombudsman may require additional information from health care providers or the board.

Subd. 5. **Written notice of disposition.** The ombudsman shall send a written notice of the final disposition of the grievance, and the reasons for the decision, to the complainant, to any provider who is assisting the complainant, and to the board, within 30 calendar days of receipt of the request for review unless the ombudsman determines that additional time is reasonably necessary to fully and fairly evaluate the relevant grievance. The ombudsman's order of corrective action shall be binding on the Minnesota Health Plan. Decisions of the ombudsman may be appealed in district court.

Sec. 9. **[62V.12] INSPECTOR GENERAL FOR THE MINNESOTA HEALTH PLAN.**

Subdivision 1. **Establishment.** There is within the Office of the Attorney General an inspector general for the Minnesota Health Plan who is appointed by the attorney general.

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

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

(2) investigate allegations of misconduct on the part of an employee or appointee of the Minnesota Health Board and on the part of any provider of health care services that is reimbursed by the Minnesota Health Plan, and report any findings of misconduct to the attorney general;

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

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

(5) annually report recommendations for improvements to the Minnesota Health Plan to the board.

Sec. 10. **[62V.13] EXAMINATION BY LEGISLATIVE AUDITOR.**

The books and all operating policies and procedures of the Minnesota Health Board shall be subject to examination by the legislative auditor.

ARTICLE 7
IMPLEMENTATION

Section 1. **APPROPRIATION.**

$..... is appropriated in fiscal year 2010 from the general fund to the Minnesota Health Fund under the Minnesota Health Plan to provide start-up funding for the provisions of this act.

Sec. 2. **REPEALER.**

Provider tax .....

MNCARE .....

Parts of Medical Assistance .....

General Assistance medical care .....

Sec. 3. **EFFECTIVE DATE AND TRANSITION.**

Subdivision 1. **Notice and effective date.** This act is effective the day following final enactment. The commissioner of finance shall notify the chairs of the house of representatives and senate committees with jurisdiction over health care when the Minnesota Health Fund has sufficient revenues to fund the costs of implementing this act.

Subd. 2. **Timing to implement.** The Minnesota Health Plan must be operational within two years from the date of final enactment of this act.

Subd. 3. **Prohibition.** On and after the day the Minnesota Health Plan becomes operational, a health plan, as defined in Minnesota Statutes, section 62Q.01, subdivision 3, may not be sold in Minnesota for services provided by the Minnesota Health Plan.

Subd. 4. **Transition.** (a) The commissioners of health and human services shall prepare an analysis of the state's capital expenditure needs for the purpose of assisting the board in adopting the statewide capital budget for the year following implementation. The commissioners shall submit this analysis to the board.

(b) The following timelines shall be implemented:

(1) the commissioner of health shall designate the health planning regions utilizing the criteria specified in Minnesota Statutes, section 62V.07, three months after the date of enactment of this act;

(2) the regional boards shall be established six months after the date of enactment of this act; and

(3) the Minnesota Health Board shall be established nine months after the date of enactment of this act; and

(4) the commissioner of health, or the commissioner's designee, shall convene the first meeting of each of the regional boards and the Minnesota Health Board within 30 days after each of the boards has been established.

APPENDIX
Article locations in 09-1101