Senate Language S1458-2

House Language UES1458-1

ARTICLE 8
HEALTH CARE DELIVERY

Section 1. **[62A.67] SHORT TITLE.**

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 2. **[62A.671] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Health carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or vendor of medical care defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

ARTICLE 6
PUBLIC HEALTH AND HEALTH CARE DELIVERY

Section 1. **[62A.67] SHORT TITLE.**

Sections 62A.67 to 62A.672 may be cited as the "Minnesota Telemedicine Act."

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 2. **[62A.671] DEFINITIONS.**

Subdivision 1. **Applicability.** For purposes of sections 62A.67 to 62A.672, the terms defined in this section have the meanings given.

Subd. 2. **Distant site.** "Distant site" means a site at which a licensed health care provider is located while providing health care services or consultations by means of telemedicine.

Subd. 3. **Health care provider.** "Health care provider" has the meaning provided in section 62A.63, subdivision 2.

Subd. 4. **Heath carrier.** "Health carrier" has the meaning provided in section 62A.011, subdivision 2.

Subd. 5. **Health plan.** "Health plan" means a health plan as defined in section 62A.011, subdivision 3, and includes dental plans as defined in section 62Q.76, subdivision 3, but does not include dental plans that provide indemnity-based benefits, regardless of expenses incurred and are designed to pay benefits directly to the policyholder.

Subd. 6. **Licensed health care provider.** "Licensed health care provider" means a health care provider who is:

(1) licensed under chapter 147, 147A, 148, 148B, 148E, 148F, 150A, or 153; a mental health professional as defined under section 245.462, subdivision 18, or 245.4871, subdivision 27; or a vendor of medical care as defined in section 256B.02, subdivision 7; and

(2) authorized within their respective scope of practice to provide the particular service with no supervision or under general supervision.

Subd. 7. **Originating site.** "Originating site" means a site including, but not limited to, a health care facility at which a patient is located at the time health care services are provided to the patient by means of telemedicine.

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Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmissions does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 3. **[62A.672] COVERAGE OF TELEMEDICINE SERVICES.**

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

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Subd. 8. **Store-and-forward technology.** "Store-and-forward technology" means the transmission of a patient's medical information from an originating site to a health care provider at a distant site without the patient being present, or the delivery of telemedicine that does not occur in real time via synchronous transmissions.

Subd. 9. **Telemedicine.** "Telemedicine" means the delivery of health care services or consultations while the patient is at an originating site and the licensed health care provider is at a distant site. A communication between licensed health care providers that consists solely of a telephone conversation, e-mail, or facsimile transmissions does not constitute telemedicine consultations or services. Telemedicine may be provided by means of real-time two-way, interactive audio and visual communications, including the application of secure video conferencing or store-and-forward technology to provide or support health care delivery, which facilitate the assessment, diagnosis, consultation, treatment, education, and care management of a patient's health care.

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

Sec. 3. **[62A.672] COVERAGE OF TELEMEDICINE SERVICES.**

Subdivision 1. **Coverage of telemedicine.** (a) A health plan sold, issued, or renewed by a health carrier for which coverage of benefits begins on or after January 1, 2017, shall include coverage for telemedicine benefits in the same manner as any other benefits covered under the policy, plan, or contract, and shall comply with the regulations of this section.

(b) Nothing in this section shall be construed to:

(1) require a health carrier to provide coverage for services that are not medically necessary;

(2) prohibit a health carrier from establishing criteria that a health care provider must meet to demonstrate the safety or efficacy of delivering a particular service via telemedicine for which the health carrier does not already reimburse other health care providers for delivering via telemedicine, so long as the criteria are not unduly burdensome or unreasonable for the particular service; or

(3) prevent a health carrier from requiring a health care provider to agree to certain documentation or billing practices designed to protect the health carrier or patients from fraudulent claims so long as the practices are not unduly burdensome or unreasonable for the particular service.

Subd. 2. **Parity between telemedicine and in-person services.** A health carrier shall not exclude a service for coverage solely because the service is provided via telemedicine and is not provided through in-person consultation or contact between a licensed health care provider and a patient.

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Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine on the same basis and at the same rate as the health carrier would apply to those services if the services had been delivered in person by the distant site licensed health care provider.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

Subd. 4. **Originating site facility fee payment.** If a health care provider provides the facility used as the originating site for the delivery of telemedicine to a health carrier's enrollee, the health carrier shall make a facility fee payment to the originating site health care provider. The facility fee payment to the originating site health care provider shall be in addition to the reimbursement to the distant site licensed health care provider specified in subdivision 3. The facility fee payment shall not be subject to any patient coinsurance, deductible, or co-payment obligation.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 4. Minnesota Statutes 2014, section 62J.497, subdivision 1, is amended to read:

Subdivision 1. **Definitions.** For the purposes of this section, the following terms have the meanings given.

(a) "Backward compatible" means that the newer version of a data transmission standard would retain, at a minimum, the full functionality of the versions previously adopted, and would permit the successful completion of the applicable transactions with entities that continue to use the older versions.

(b) "Dispense" or "dispensing" has the meaning given in section 151.01, subdivision 30. Dispensing does not include the direct administering of a controlled substance to a patient by a licensed health care professional.

(c) "Dispenser" means a person authorized by law to dispense a controlled substance, pursuant to a valid prescription.

(d) "Electronic media" has the meaning given under Code of Federal Regulations, title 45, part 160.103.

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Subd. 3. **Reimbursement for telemedicine services.** (a) A health carrier shall reimburse the distant site licensed health care provider for covered services delivered via telemedicine commensurate with the cost of delivering health care services through telemedicine. The distant site provider is responsible for reimbursing any fees to the originating site.

(b) It is not a violation of this subdivision for a health carrier to include a deductible, co-payment, or coinsurance requirement for a health care service provided via telemedicine, provided that the deductible, co-payment, or coinsurance is not in addition to, and does not exceed, the deductible, co-payment, or coinsurance applicable if the same services were provided through in-person contact.

EFFECTIVE DATE. This section is effective January 1, 2017, and applies to coverage offered, sold, issued, or renewed on or after that date.

(e) "E-prescribing" means the transmission using electronic media of prescription or prescription-related information between a prescriber, dispenser, pharmacy benefit manager, or group purchaser, either directly or through an intermediary, including an e-prescribing network. E-prescribing includes, but is not limited to, two-way transmissions between the point of care and the dispenser and two-way transmissions related to eligibility, formulary, and medication history information.

(f) "Electronic prescription drug program" means a program that provides for e-prescribing.

(g) "Group purchaser" has the meaning given in section 62J.03, subdivision 6, but does not include workers' compensation plans or the medical component of automobile insurance coverage.

(h) "HL7 messages" means a standard approved by the standards development organization known as Health Level Seven.

(i) "National Provider Identifier" or "NPI" means the identifier described under Code of Federal Regulations, title 45, part 162.406.

(j) "NCPDP" means the National Council for Prescription Drug Programs, Inc.

(k) "NCPDP Formulary and Benefits Standard" means the National Council for Prescription Drug Programs Formulary and Benefits Standard, Implementation Guide, Version 1, Release 0, October 2005.

(l) "NCPDP SCRIPT Standard" means the National Council for Prescription Drug Programs Prescriber/Pharmacist Interface SCRIPT Standard, Implementation Guide Version 8, Release 1 (Version 8.1), October 2005, or the most recent standard adopted by the Centers for Medicare and Medicaid Services for e-prescribing under Medicare Part D as required by section 1860D-4(e)(4)(D) of the Social Security Act, and regulations adopted under it. The standards shall be implemented according to the Centers for Medicare and Medicaid Services schedule for compliance. Subsequently released versions of the NCPDP SCRIPT Standard may be used, provided that the new version of the standard is backward compatible to the current version adopted by the Centers for Medicare and Medicaid Services.

(m) "Pharmacy" has the meaning given in section 151.01, subdivision 2.

(n) "Prescriber" means a licensed health care practitioner, other than a veterinarian, as defined in section 151.01, subdivision 23.

(o) "Prescription-related information" means information regarding eligibility for drug benefits, medication history, or related health or drug information.

(p) "Provider" or "health care provider" has the meaning given in section 62J.03, subdivision 8.

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(q) "Utilization review organization" has the meaning given in section 62M.02, subdivision 21.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 5. Minnesota Statutes 2014, section 62J.497, subdivision 3, is amended to read:

Subd. 3. **Standards for electronic prescribing.** (a) Prescribers and dispensers must use the NCPDP SCRIPT Standard for the communication of a prescription or prescription-related information. The NCPDP SCRIPT Standard shall be used to conduct the following transactions:

(1) get message transaction;

(2) status response transaction;

(3) error response transaction;

(4) new prescription transaction;

(5) prescription change request transaction;

(6) prescription change response transaction;

(7) refill prescription request transaction;

(8) refill prescription response transaction;

(9) verification transaction;

(10) password change transaction;

(11) cancel prescription request transaction; and

(12) cancel prescription response transaction.

(b) Providers, group purchasers, prescribers, and dispensers must use the NCPDP SCRIPT Standard for communicating and transmitting medication history information.

(c) Providers, group purchasers, prescribers, and dispensers must use the NCPDP Formulary and Benefits Standard for communicating and transmitting formulary and benefit information.

(d) Group purchasers, prescribers, pharmacies, and utilization review organizations must collaborate to develop processes to ensure notification to prescribers upon denial of a claim for a prescribed drug that is not covered or is not included on the group purchaser's formulary. The process must provide a list of covered drugs from the same class or classes as the drug originally prescribed. If the NCPDP SCRIPT Standard or the NCPDP Formulary and Benefits Standard do not allow for the inclusion of this information, group purchasers, prescribers, pharmacies, and utilization review organizations must develop telephone, facsimile, or other secure electronic processes to communicate this information to the prescriber. The development of this process shall be done under the auspices of the administrative uniformity committee and take into consideration capabilities available in electronic medical records.

~~(d)~~ (e) Providers, group purchasers, prescribers, and dispensers must use the national provider identifier to identify a health care provider in e-prescribing or prescription-related transactions when a health care provider's identifier is required.

~~(e)~~ (f) Providers, group purchasers, prescribers, and dispensers must communicate eligibility information and conduct health care eligibility benefit inquiry and response transactions according to the requirements of section 62J.536.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 6. Minnesota Statutes 2014, section 62J.497, subdivision 4, is amended to read:

Subd. 4. **Development and use of uniform formulary exception form.** (a) The commissioner of health, in consultation with the Minnesota Administrative Uniformity Committee, shall develop by July 1, 2009, a uniform formulary exception form that allows health care providers to request exceptions from group purchaser formularies using a uniform form. Upon development of the form, all health care providers must submit requests for formulary exceptions using the uniform form, and all group purchasers must accept this form from health care providers.

(b) ~~No later than January 1, 2011,~~ The uniform formulary exception form must be accessible and submitted by health care providers, and accepted and processed by group purchasers, through secure electronic transmissions. No later than September 1, 2015, the uniform formulary exception form shall be updated to reflect evolving pharmacy and prior authorization requirements.

(c) Health care providers, group purchasers, prescribers, dispensers, and utilization review organizations using paper forms for prescription drug prior authorization or for medical exception requests as defined in section 62Q.85, subdivision 5, must only use the uniform formulary exception form.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 7. Minnesota Statutes 2014, section 62J.497, subdivision 5, is amended to read:

Subd. 5. **Electronic drug prior authorization standardization and transmission.** (a) The commissioner of health, in consultation with the Minnesota e-Health Advisory Committee and the Minnesota Administrative Uniformity Committee, shall, by February 15, 2010, identify an outline on how best to standardize drug prior authorization request transactions between providers and group purchasers with the goal of maximizing administrative simplification and efficiency in preparation for electronic transmissions.

(b) By January 1, 2014, the Minnesota Administrative Uniformity Committee shall develop the standard companion guide by which providers and group purchasers will exchange standard drug authorization requests using electronic data interchange standards, if available, with the goal of alignment with standards that are or will potentially be used nationally.

(c) Testing of the electronic drug prior authorization transmission must begin no later than October 1, 2015.

(d) No later than January 1, 2016, drug prior authorization requests must be accessible and submitted by health care providers, and accepted by group purchasers, electronically through secure electronic transmissions. Facsimile shall not be considered electronic transmission.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 8. Minnesota Statutes 2014, section 62M.01, subdivision 2, is amended to read:

Subd. 2. **Jurisdiction.** (a) Sections 62M.01 to ~~62M.16~~ 62M.17 apply to any insurance company licensed under chapter 60A to offer, sell, or issue a policy of accident and sickness insurance as defined in section 62A.01; a health service plan licensed under chapter 62C; a health maintenance organization licensed under chapter 62D; the Minnesota Comprehensive Health Association created under chapter 62E; a community integrated service network licensed under chapter 62N; an accountable provider network operating under chapter 62T; a fraternal benefit society operating under chapter 64B; a joint self-insurance employee health plan operating under chapter 62H; a multiple employer welfare arrangement, as defined in section 3 of the Employee Retirement Income Security Act of 1974 (ERISA), United States Code, title 29, section 1103, as amended; a third-party administrator licensed under section 60A.23, subdivision 8, that provides utilization review services for the administration of benefits under a health benefit plan as defined in section 62M.02; or any entity performing utilization review on behalf of a business entity in this state pursuant to a health benefit plan covering a Minnesota resident.

(b) Sections 62M.01 to 62M.17 do not apply to the medical assistance fee-for-service program under chapter 256B, unless otherwise required in law or regulation.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 9. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 10a. **Drug.** "Drug" has the meaning given in section 151.01, subdivision 5.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 10. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 11a. **Formulary.** "Formulary" has the meaning given in section 62Q.85, subdivision 1.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 11. Minnesota Statutes 2014, section 62M.02, subdivision 12, is amended to read:

Subd. 12. **Health benefit plan.** "Health benefit plan" means a policy, contract, or certificate issued by a health plan company for the coverage of medical, dental, prescription drug, or hospital benefits. A health benefit plan does not include coverage that is:

(1) limited to disability or income protection coverage;

(2) automobile medical payment coverage;

(3) supplemental to liability insurance;

(4) designed solely to provide payments on a per diem, fixed indemnity, or nonexpense incurred basis;

(5) credit accident and health insurance issued under chapter 62B;

(6) blanket accident and sickness insurance as defined in section 62A.11;

(7) accident only coverage issued by a licensed and tested insurance agent; or

(8) workers' compensation.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 12. Minnesota Statutes 2014, section 62M.02, subdivision 14, is amended to read:

Subd. 14. **Outpatient services.** "Outpatient services" means procedures or services performed on a basis other than as an inpatient, and includes obstetrical, psychiatric, chemical dependency, dental, prescription drug, and chiropractic services.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 13. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14b. **Prescription.** "Prescription" has the meaning given in section 151.01, subdivision 16a.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 14. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 14c. **Prescription drug order.** "Prescription drug order" has the meaning given in section 151.01, subdivision 16.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 15. Minnesota Statutes 2014, section 62M.02, subdivision 15, is amended to read:

Subd. 15. **Prior authorization.** "Prior authorization" means utilization review conducted prior to the delivery of a service, including an outpatient service. Prior authorization includes, but is not limited to, preadmission review, pretreatment review, quantity limits, step therapy, utilization, and case management. Prior authorization also includes any utilization review organization's requirement that an enrollee or provider notify the utilization review organization prior to providing a service, including an outpatient service. Reviews performed for emergency medical assistance benefits, medical assistance waivered services, or the Minnesota restricted recipient program are not prior authorization.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 16. Minnesota Statutes 2014, section 62M.02, subdivision 17, is amended to read:

Subd. 17. **Provider.** "Provider" means a licensed health care facility, physician, pharmacist, or other health care professional that delivers health care services to an enrollee.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 17. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 18a. **Quantity limit.** "Quantity limit" means a limit on the number of doses of a prescription drug that are covered during a specific time period.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 18. Minnesota Statutes 2014, section 62M.02, is amended by adding a subdivision to read:

Subd. 19a. **Step therapy.** "Step therapy" means clinical practice or other evidence-based protocols or requirements that specify the sequence in which different prescription drugs for a given medical condition are to be used by an enrollee before a drug prescribed by a provider is covered. Step therapy does not include a requirement for an enrollee to use a generic or biosimilar product considered by the Food and Drug Administration to be therapeutically equivalent and interchangeable to a branded product, provided the generic or biosimilar product has not previously been tried by the patient.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 19. Minnesota Statutes 2014, section 62M.05, subdivision 3a, is amended to read:

Subd. 3a. **Standard review determination.** (a) Notwithstanding subdivision 3b, an initial determination on all requests for utilization review, except a determination related to prescription drugs, must be communicated to the provider and enrollee in accordance with this subdivision within ten business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(b) An initial determination for utilization review on all prescription drug requests must be communicated to the provider and enrollee in accordance with this subdivision within five business days of the request, provided that all information reasonably necessary to make a determination on the request has been made available to the utilization review organization.

(c) When an initial determination is made to certify, notification must be provided promptly by telephone to the provider. The utilization review organization shall send written notification to the provider or shall maintain an audit trail of the determination and telephone notification. For purposes of this subdivision, "audit trail" includes documentation of the telephone notification, including the date; the name of the person spoken to; the enrollee; the service, procedure, or admission certified; and the date of the service, procedure, or admission. If the utilization review organization indicates certification by use of a number, the number must be called the "certification number." For purposes of this subdivision, notification may also be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. These electronic forms of notification satisfy the "audit trail" requirement of this paragraph.

~~(c)~~ (d) When an initial determination is made not to certify, notification must be provided by telephone, by facsimile to a verified number, or by electronic mail to a secure electronic mailbox within one working day after making the determination to the attending health care professional and hospital as applicable. Written notification must also be sent to the hospital as applicable and attending health care professional if notification occurred by telephone. For purposes of this subdivision, notification may be made by facsimile to a verified number or by electronic mail to a secure electronic mailbox. Written notification must be sent to the enrollee and may be sent by United States mail, facsimile to a verified number, or by electronic mail to a secure mailbox. The written notification must include the principal reason or reasons for the determination and the process for initiating an appeal of the determination. Upon request, the utilization review organization shall provide the provider or enrollee with the criteria used to determine the necessity, appropriateness, and efficacy of the health care service and identify the database, professional treatment parameter, or other basis for the criteria. Reasons for a determination not to certify may include, among other things, the lack of adequate information to certify after a reasonable attempt has been made to contact the provider or enrollee.

~~(d)~~ (e) When an initial determination is made not to certify, the written notification must inform the enrollee and the attending health care professional of the right to submit an appeal to the internal appeal process described in section 62M.06 and the procedure for initiating the internal appeal. The written notice shall be provided in a culturally and linguistically appropriate manner consistent with the provisions of the Affordable Care Act as defined under section 62A.011, subdivision 1a.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 20. Minnesota Statutes 2014, section 62M.05, subdivision 3b, is amended to read:

Subd. 3b. **Expedited review determination.** (a) An expedited initial determination must be utilized if the attending health care professional believes that an expedited determination is warranted.

(b) Notification of an expedited initial determination to either certify or not to certify, except a determination related to prescription drugs, must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 72 hours from the initial request. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

(c) Notification of an expedited initial determination to either certify or not to certify on all prescription drug requests must be provided to the hospital, the attending health care professional, and the enrollee as expeditiously as the enrollee's medical condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. For state public health care programs administered under section 256B.69 and chapter 256L, notification must be provided to the hospital, attending health care provider, or the enrollee as expeditiously as the enrollee's condition requires, but no later than 36 hours from the initial request, provided that all the information reasonably necessary to make a determination has been made available to the utilization review organization. When an expedited initial determination is made not to certify, the utilization review organization must also notify the enrollee and the attending health care professional of the right to submit an appeal to the expedited internal appeal as described in section 62M.06 and the procedure for initiating an internal expedited appeal.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 21. Minnesota Statutes 2014, section 62M.05, subdivision 4, is amended to read:

Subd. 4. **Failure to provide necessary information.** A utilization review organization must have written procedures to address the failure of a provider or enrollee to provide the necessary information for review, and to address processes by which the utilization review organization must track and manage review requests and documentation submitted by providers or enrollees. If the enrollee or provider will not release the necessary information to the utilization review organization, the utilization review organization may deny certification in accordance with its own policy or the policy described in the health benefit plan. If a utilization review organization fails to meet the timelines in subdivision 3a or 3b for a completed prescription drug review request, or fails to notify the provider that information needed to conduct the prescription drug review is incomplete, or if a utilization review organization fails to properly maintain submitted records for which the provider or enrollee has documentation of submission, the service shall be deemed approved.

EFFECTIVE DATE. This section is effective January 1, 2017.

Senate Language S1458-2

House Language UES1458-1

Sec. 22. Minnesota Statutes 2014, section 62M.06, subdivision 2, is amended to read:

Subd. 2. **Expedited appeal.** (a) When an initial determination not to certify a health care service is made prior to or during an ongoing service requiring review and the attending health care professional believes that the determination warrants an expedited appeal, the utilization review organization must ensure that the enrollee and the attending health care professional have an opportunity to appeal the determination over the telephone on an expedited basis. In such an appeal, the utilization review organization must ensure reasonable access to its consulting physician or health care provider.

(b) The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination, except for determinations related to prescription drugs, on the expedited appeal as expeditiously as the enrollee's medical condition requires, but no later than 72 hours after receiving the expedited appeal. The utilization review organization shall notify the enrollee and attending health care professional by telephone of its determination on the expedited appeal of a prescription drug request as expeditiously as the enrollee's medical condition requires, but no later than 36 hours after receiving the expedited appeal.

(c) If the determination not to certify is not reversed through the expedited appeal, the utilization review organization must include in its notification the right to submit the appeal to the external appeal process described in section 62Q.73 and the procedure for initiating the process. This information must be provided in writing to the enrollee and the attending health care professional as soon as practical.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 23. Minnesota Statutes 2014, section 62M.06, subdivision 3, is amended to read:

Subd. 3. **Standard appeal.** The utilization review organization must establish procedures for appeals to be made either in writing or by telephone.

(a) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal, except for determinations related to prescription drugs, within 30 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination within 30 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to 14 additional days to notify the enrollee, attending health care professional, and claims administrator of its determination. If the utilization review organization takes any additional days beyond the initial 30-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

Senate Language S1458-2

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(b) A utilization review organization shall notify in writing the enrollee, attending health care professional, and claims administrator of its determination on the appeal on a prescription drug within 15 days upon receipt of the notice of appeal. If the utilization review organization cannot make a determination on a prescription drug within 15 days due to circumstances outside the control of the utilization review organization, the utilization review organization may take up to ten additional days to notify the enrollee, attending health care professional, and claims administration of its determination. If the utilization review organization takes any additional days beyond the initial 15-day period to make its determination, it must inform the enrollee, attending health care professional, and claims administrator, in advance, of the extension and the reasons for the extension.

(c) The documentation required by the utilization review organization may include copies of part or all of the medical record and a written statement from the attending health care professional.

~~(c)~~ (d) Prior to upholding the initial determination not to certify for clinical reasons, the utilization review organization shall conduct a review of the documentation by a physician who did not make the initial determination not to certify.

~~(d)~~ (e) The process established by a utilization review organization may include defining a period within which an appeal must be filed to be considered. The time period must be communicated to the enrollee and attending health care professional when the initial determination is made.

~~(e)~~ (f) An attending health care professional or enrollee who has been unsuccessful in an attempt to reverse a determination not to certify shall, consistent with section 72A.285, be provided the following:

(1) a complete summary of the review findings;

(2) qualifications of the reviewers, including any license, certification, or specialty designation; and

(3) the relationship between the enrollee's diagnosis and the review criteria used as the basis for the decision, including the specific rationale for the reviewer's decision.

~~(f)~~ (g) In cases of appeal to reverse a determination not to certify for clinical reasons, the utilization review organization must ensure that a physician of the utilization review organization's choice in the same or a similar specialty as typically manages the medical condition, procedure, or treatment under discussion is reasonably available to review the case.

~~(g)~~ (h) If the initial determination is not reversed on appeal, the utilization review organization must include in its notification the right to submit the appeal to the external review process described in section 62Q.73 and the procedure for initiating the external process.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 24. Minnesota Statutes 2014, section 62M.07, is amended to read:

62M.07 PRIOR AUTHORIZATION OF SERVICES.

(a) Utilization review organizations conducting prior authorization of services must have written standards that meet at a minimum the following requirements:

(1) written procedures and criteria used to determine whether care is appropriate, reasonable, or medically necessary;

(2) a system for providing prompt notification of its determinations to enrollees and providers and for notifying the provider, enrollee, or enrollee's designee of appeal procedures under clause (4);

(3) compliance with section 62M.05, subdivisions 3a and 3b, regarding time frames for approving and disapproving prior authorization requests;

(4) written procedures for appeals of denials of prior authorization which specify the responsibilities of the enrollee and provider, and which meet the requirements of sections 62M.06 and 72A.285, regarding release of summary review findings; and

(5) procedures to ensure confidentiality of patient-specific information, consistent with applicable law.

(b) No utilization review organization, health plan company, or claims administrator may conduct or require prior authorization of emergency confinement or emergency treatment. The enrollee or the enrollee's authorized representative may be required to notify the health plan company, claims administrator, or utilization review organization as soon after the beginning of the emergency confinement or emergency treatment as reasonably possible.

(c) If prior authorization for a health care service is required, the utilization review organization, health plan company, or claim administrator must allow providers to submit requests for prior authorization of the health care services without unreasonable delay by telephone, facsimile, or voice mail or through an electronic mechanism 24 hours a day, seven days a week. This paragraph does not apply to dental service covered under MinnesotaCare, general assistance medical care, or medical assistance.

(d) Any prior authorization for a prescription drug must remain valid for the duration of an enrollee's benefit year, or for the benefits offered under section 256B.69 or chapter 256L, any prior authorization for a prescription drug must remain valid for the duration of the enrollee's enrollment or one year, whichever is shorter, provided the drug continues to be prescribed for a patient with a condition that requires ongoing medication therapy, the drug has not otherwise been deemed unsafe by the Food and Drug Administration, has not been withdrawn by the manufacturer or the Food and Drug Administration, there is no evidence of the enrollee's abuse or misuse of the medication, or no independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage. This does not apply to individuals assigned to the restricted recipient program under Minnesota Rules, parts 9505.2160 to 9505.2245.

(e) No utilization review organization, health plan company, or claims administrator may impose step therapy requirements for enrollees currently taking a prescription drug, as substantiated from available claims data or provider documentation, in one of the following classes: (1) immunosuppressants; (2) antidepressants; (3) antipsychotics; (4) anticonvulsants; (5) antiretrovirals; or (6) antineoplastics. This provision does not apply to a patient who has initiated treatment for a condition with samples provided by a prescriber and provided that any step therapy requirements subsequently applied are consistent with evidence-based prescribing practices.

EFFECTIVE DATE. This section is effective January 1, 2017.

Sec. 25. Minnesota Statutes 2014, section 62M.09, subdivision 3, is amended to read:

Subd. 3. **Physician reviewer involvement.** (a) A physician must review all cases in which the utilization review organization has concluded that a determination not to certify for clinical reasons is appropriate.

(b) The physician conducting the review must be licensed in this state. ~~This paragraph does not apply to reviews conducted in connection with policies issued by a health plan company that is assessed less than three percent of the total amount assessed by the Minnesota Comprehensive Health Association.~~

(c) The physician should be reasonably available by telephone to discuss the determination with the attending health care professional.

(d) This subdivision does not apply to outpatient mental health or substance abuse services governed by subdivision 3a.

EFFECTIVE DATE. This section is effective January 1, 2017.

Sec. 26. Minnesota Statutes 2014, section 62M.10, subdivision 7, is amended to read:

Subd. 7. **Availability of criteria.** Upon request, a utilization review organization shall provide to an enrollee, a provider, and the commissioner of commerce the written clinical criteria used to determine the medical necessity, appropriateness, and efficacy of a procedure or service and identify the database, professional treatment guideline, or other basis for the criteria. This requirement may be met by posting the written clinical criteria on the utilization review organization's public Web site or electronically distributing the information directly to the enrollee or provider.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 27. Minnesota Statutes 2014, section 62M.11, is amended to read:

62M.11 COMPLAINTS TO COMMERCE OR HEALTH.

Notwithstanding the provisions of sections 62M.01 to 62M.16, an enrollee or provider may file a complaint regarding compliance with the requirements of this chapter or regarding a determination not to certify directly to the commissioner responsible for regulating the utilization review organization.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 28. **[62M.17] REPORTING.**

On August 1, 2016, and each August 1 thereafter, utilization review organizations must report to the commissioner of health, on the forms and in the manner specified by the commissioner, the following information:

(1) for medical exception requests, the 25 most frequently requested drugs by exception type, including lack of available clinical alternative, ineffective formulary drug, and dosage limits; and

(2) for prescription drug prior authorization requests:

(i) the number and rate of initial approvals by commercial product and by prepaid medical assistance product types;

(ii) the number and rate of standard appeal approvals by commercial product and by prepaid medical assistance product types;

(iii) the number and rate of expedited appeal approvals by commercial product and by prepaid medical assistance product types;

(iv) for standard reviews, the range and average time from receipt of completed request to notification of decision;

(v) for expedited reviews, the range and average time from receipt of completed request to notification of decision;

(vi) for standard appeals, the range and average time from receipt of completed request to notification of decision; and

(vii) for expedited appeals, the range and average time from receipt of completed request to notification of decision.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 29. Minnesota Statutes 2014, section 62Q.02, is amended to read:

62Q.02 APPLICABILITY OF CHAPTER.

(a) This chapter applies only to health plans, as defined in section 62Q.01, and not to other types of insurance issued or renewed by health plan companies, unless otherwise specified.

(b) This chapter applies to a health plan company only with respect to health plans, as defined in section 62Q.01, issued or renewed by the health plan company, unless otherwise specified.

(c) If a health plan company issues or renews health plans in other states, this chapter applies only to health plans issued or renewed in this state for Minnesota residents, or to cover a resident of the state, unless otherwise specified.

(d) This chapter does not apply to public health care programs administered by the commissioner of human services under chapter 256B or 256L, unless otherwise required by law or regulation.

Sec. 30. **[62Q.83] FREEDOM OF CHOICE FOR PHARMACY SERVICES.**

Subdivision 1. **Enrollee choice.** No health plan company or pharmacy benefit manager that covers pharmaceutical services, including prescription drug coverage, shall limit or restrict an enrollee's ability to select a pharmacy or pharmacist of the enrollee's choice if the pharmacy or pharmacist is licensed under chapter 151, and the pharmacy or pharmacist has agreed to the terms of the health plan company's or pharmacy benefit manager's provider contract.

This subdivision does not apply to an enrollee in the Minnesota restricted recipient program pursuant to Minnesota Rules, part 9505.2238.

Subd. 2. **Provider network.** No health plan company or pharmacy benefit manager shall deny a pharmacy or pharmacist the right to participate in any of its pharmacy network contracts in this state or as a contracting provider in this state if the pharmacy or pharmacist has a valid license under chapter 151, and the pharmacy or pharmacist agrees to accept the terms and conditions offered by the health plan company or pharmacy benefit manager, and agrees to provide pharmacy services that meet state and federal laws and regulations.

Subd. 3. **Cost-sharing or other conditions.** No health plan company or pharmacy benefit manager shall impose a co-payment, fee, or other cost-sharing requirement for selecting a pharmacy or pharmacist of the enrollee's choosing or impose other conditions that limit or restrict an enrollee's ability to utilize a pharmacy of the enrollee's choosing, unless the health plan company or pharmacy benefit manager imposes the same cost-sharing requirements, fees, conditions, or limits upon an enrollee's selection of any of the pharmacies within the health plan company's or pharmacy benefit manager's provider network contracts in this state.

Subd. 4. **Definitions.** (a) For purposes of this section, the terms in this subdivision have the meanings given.

(b) "Pharmacy" has the meaning given in section 151.01, subdivision 2, and includes mail order pharmacies and specialty pharmacies.

(c) "Pharmacy benefit manager" has the meaning given in section 151.71, subdivision 1.

EFFECTIVE DATE. This section is effective August 1, 2015, and applies to any health plan issued or renewed on or after that date.

Sec. 31. **[62Q.84] SERVICES PERFORMED BY A PHARMACIST.**

A health plan company or pharmacy benefit manager, as defined under section 151.71, subdivision 1, shall provide payment for any health care service that is a covered benefit and is performed by a licensed pharmacist if: (1) the service performed is within the scope of practice of a licensed pharmacist under chapter 151; and (2) the health plan would cover the service if the service was performed by a physician licensed under chapter 147; an advanced practice registered nurse licensed under section 148.211, subdivision 1a; or a physician assistant licensed under chapter 147A.

EFFECTIVE DATE. This section is effective August 1, 2015, and applies to any health plan issued or renewed on or after that date.

Sec. 32. **[62Q.85] PRESCRIPTION DRUG BENEFIT TRANSPARENCY AND MANAGEMENT.**

Subdivision 1. **Definitions.** (a) For purposes of this section, the following terms have the meaning given them.

(b) "Drug" has the meaning given in section 151.01, subdivision 5.

(c) "Formulary" means a list of prescription drugs that have been developed by clinical and pharmacy experts and represents the health plan company's medically appropriate and cost-effective prescription drugs approved for use.

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(d) "Health plan company" has the meaning given in section 62Q.01, subdivision 4, and includes an entity that performs pharmacy benefits management for the health plan company. For purposes of this definition, "pharmacy benefits management" means the administration or management of prescription drug benefits provided by the health plan company for the benefit of its enrollees and may include, but is not limited to, procurement of prescription drugs, clinical formulary development and management services, claims processing, and rebate contracting and administration.

(e) "Prescription" has the meaning given in section 151.01, subdivision 16a.

Subd. 2. **Prescription drug benefit disclosure.** (a) A health plan company that provides prescription drug benefit coverage and uses a formulary must make its formulary and related benefit information available by electronic means and, upon request, in writing, at least 30 days prior to annual renewal dates.

(b) Formularies must be organized and disclosed consistent with the most recent version of the United States Pharmacopeia's (USP) Model Guidelines.

(c) For each item or category of items on the formulary, the specific enrollee benefit terms must be identified, including enrollee cost-sharing and expected out-of-pocket costs.

Subd. 3. **Formulary changes.** (a) Once a formulary has been established, a health plan company may, at any time during the enrollee's benefit year:

(1) expand its formulary by adding drugs to the formulary;

(2) reduce co-payments or coinsurance; or

(3) move a drug to a benefit category that reduces an enrollee's cost.

(b) A health plan company may remove a brand name drug from its formulary or place a brand name drug in a benefit category that increases an enrollee's cost only upon the addition to the formulary of an A-rated generic or multisource brand name equivalent at a lower cost to the enrollee, and upon at least a 60-day notice to prescribers, pharmacists, and affected enrollees.

(c) A health plan company is prohibited from removing drugs from its formulary or moving drugs to a benefit category that increases an enrollee's cost during the enrollee's benefit year. This paragraph does not apply to any changes associated with drugs that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or where an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

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(d) Managed care plans and county-based purchasing plans under section 256B.69 and chapter 256L, are prohibited from removing drugs from its formulary or moving drugs to a benefit category that increases an enrollee's cost more than once annually unless an A-rated generic or multisource brand name equivalent is added to the formulary. This paragraph does not apply to any changes associated with drugs that have been deemed unsafe by the Food and Drug Administration, that have been withdrawn by either the Food and Drug Administration or the product manufacturer, or where an independent source of research, clinical guidelines, or evidence-based standards has issued drug-specific warnings or recommended changes in drug usage.

Subd. 4. **Transition process.** (a) A health plan company must establish and maintain a transition process to prevent gaps in prescription drug coverage for both new and continuing enrollees with ongoing prescription drug needs who are affected by changes in formulary drug availability.

(b) The transition process must provide coverage for at least 60 days.

(c) Any enrollee cost-sharing applied must be based on the defined prescription drug benefit terms and must be consistent with any cost-sharing that the health plan company would charge for nonformulary drugs approved under a medication exceptions process.

(d) A health plan company must ensure that written notice is provided to each affected enrollee and prescriber within three business days after adjudication of the transition coverage.

Subd. 5. **Medication exceptions process.** (a) Each health plan company must establish and maintain a medication exceptions process that allows enrollees, providers, or an enrollee's authorized representative to request and obtain coverage approval for medications in the following situations:

(1) there is no acceptable clinical alternative listed on the formulary to treat the enrollee's disease or medical condition;

(2) the prescription listed on the formulary has been ineffective in the treatment of an enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance; or

(3) the number of doses that are available under a dose restriction has been ineffective in the treatment of the enrollee's disease or medical condition or, based on clinical and scientific evidence and the relevant physical or mental characteristics of the enrollee, is likely to be ineffective or adversely affect the drug's effectiveness or the enrollee's medication compliance.

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(b) An approved medication exception request must remain valid for the duration of an enrollee's benefit term, or for benefits offered under section 265B.69 or chapter 256L, for the duration of the enrollee's enrollment, or one year, whichever is shorter, provided the medication continues to be prescribed for the same condition, and the medication has not otherwise been withdrawn by the manufacturer or the Food and Drug Administration.

(c) The medication exceptions process must comply with the requirements of chapter 62M.

Subd. 6. **Prescription Drug Advisory Council.** (a) A Prescription Drug Advisory Council has 11 members appointed by the commissioner of health with representation as follows:

(1) three patients;

(2) one physician licensed to practice medicine in Minnesota;

(3) two nonphysicians who are licensed in Minnesota to prescribe prescription drugs;

(4) one pharmacist licensed in Minnesota;

(5) one person representing a health plan company;

(6) one person representing a pharmacy benefit manager;

(7) one person representing pharmaceutical manufacturers; and

(8) one person who purchases health benefits for a group or an employer.

(b) Terms and removal of public members are as provided in section 15.0575, except that members will serve without compensation or expense reimbursement. A vacancy on the council may be filled by the appointing authority for the remainder of the unexpired term. Vacancies will be filled as provided in section 15.0597.

(c) The council shall select a chair from among its members. The chair may convene meetings as necessary to conduct the duties prescribed by this section.

(d) The duty of the council is to provide guidance to the commissioner of health in monitoring changes and trends in prescription drug coverage and formulary design. The council must consult with the commissioner to assist the commissioner in preparing the report required under paragraph (g).

(e) The commissioner of health will provide administrative support and meeting space for the council to perform its duties.

(f) The Prescription Drug Advisory Council expires on January 30, 2021.

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(g) Beginning January 15, 2017, and on at least a biennial basis thereafter, the commissioner, in consultation with the advisory group, shall submit a report to the chairs and lead minority members of the legislative committees with jurisdiction over health care coverage describing trends in prescription drug coverage, formulary design, medication exception requests, and benefit design. Health plan companies, pharmacy benefit managers, prescribers, and pharmacies must cooperate in providing information necessary for the advisory group to carry out its responsibilities, provided the commissioner, in consultation with the affected parties, does not determine the information to be of a proprietary nature.

EFFECTIVE DATE. Subdivisions 1 to 5 are effective January 1, 2017. Subdivision 6 is effective August 1, 2015.

Sec. 33. Minnesota Statutes 2014, section 62U.02, subdivision 1, is amended to read:

Subdivision 1. **Development.** (a) The commissioner of health shall develop a standardized set of measures by which to assess the quality of health care services offered by health care providers, including health care providers certified as health care homes under section 256B.0751. Quality measures must be based on medical evidence and be developed through a process in which providers participate. The measures shall be used for the quality incentive payment system developed in subdivision 2 and must:

(1) include uniform definitions, measures, and forms for submission of data, to the greatest extent possible;

(2) seek to avoid increasing the administrative burden on health care providers;

(3) be initially based on existing quality indicators for physician and hospital services, which are measured and reported publicly by quality measurement organizations, including, but not limited to, Minnesota Community Measurement and specialty societies;

(4) place a priority on measures of health care outcomes, rather than process measures, wherever possible; and

(5) incorporate measures for primary care, including preventive services, coronary artery and heart disease, diabetes, asthma, depression, and other measures as determined by the commissioner.

(b) Effective July 1, 2016, the commissioner shall stratify five quality measures by race, ethnicity, preferred language, and country of origin. On or after January 1, 2018, the commissioner may require measures to be stratified by other sociodemographic factors that according to reliable data are correlated with health disparities and have an impact on performance on quality or cost indicators. New methods of stratifying data under this paragraph must be tested and evaluated through pilot projects prior to adding them to the statewide system. In determining whether to add additional sociodemographic factors and developing the methodology to be used, the commissioner shall consider the reporting burden on providers and determine whether there are alternative sources of data that could be used. The commissioner shall ensure that categories and data collection methods are developed in consultation with those communities impacted by health disparities using culturally appropriate community engagement principles and methods. The commissioner shall implement this paragraph in coordination with the contracting entity retained under section 62U.02, subdivision 4, in order to build upon the data stratification methodology that has been developed and tested by the entity. Nothing in this paragraph expands or changes the commissioner's authority to collect, analyze, or report health care data. Any data collected to implement this paragraph must be data that is available or is authorized to be collected under other laws. Nothing in this paragraph grants authority to the commissioner to collect or analyze patient-level or patient-specific data of the patient characteristics identified under this paragraph.

~~(b)~~ (c) The measures shall be reviewed at least annually by the commissioner.

Sec. 34. Minnesota Statutes 2014, section 62U.02, subdivision 2, is amended to read:

Subd. 2. **Quality incentive payments.** (a) By July 1, 2009, the commissioner shall develop a system of quality incentive payments under which providers are eligible for quality-based payments that are in addition to existing payment levels, based upon a comparison of provider performance against specified targets, and improvement over time. The targets must be based upon and consistent with the quality measures established under subdivision 1.

(b) To the extent possible, the payment system must adjust for variations in patient population in order to reduce incentives to health care providers to avoid high-risk patients or populations, including those with risk factors related to race, ethnicity, language, country of origin, and sociodemographic factors.

(c) The requirements of section 62Q.101 do not apply under this incentive payment system.

Sec. 35. Minnesota Statutes 2014, section 62U.02, subdivision 3, is amended to read:

Subd. 3. **Quality transparency.** (a) The commissioner shall establish standards for measuring health outcomes, establish a system for risk adjusting quality measures, and issue annual public reports on provider quality beginning July 1, 2010.

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(b) Effective July 1, 2017, the risk adjustment system established under this subdivision shall adjust for patient characteristics identified under subdivision 1, paragraph (b), that are correlated with health disparities and have an impact on performance on cost and quality measures. The risk adjustment method may consist of reporting based on an actual-to-expected comparison that reflects the characteristics of the patient population served by the clinic or hospital. The commissioner shall implement this paragraph in coordination with any contracting entity retained under section 62U.02, subdivision 4.

(c) By January 1, 2010, physician clinics and hospitals shall submit standardized electronic information on the outcomes and processes associated with patient care to the commissioner or the commissioner's designee. In addition to measures of care processes and outcomes, the report may include other measures designated by the commissioner, including, but not limited to, care infrastructure and patient satisfaction. The commissioner shall ensure that any quality data reporting requirements established under this subdivision are not duplicative of publicly reported, communitywide quality reporting activities currently under way in Minnesota. Nothing in this subdivision is intended to replace or duplicate current privately supported activities related to quality measurement and reporting in Minnesota.

Sec. 36. Minnesota Statutes 2014, section 62U.02, subdivision 4, is amended to read:

Subd. 4. **Contracting.** The commissioner may contract with a private entity or consortium of private entities to complete the tasks in subdivisions 1 to 3. The private entity or consortium must be nonprofit and have governance that includes representatives from the following stakeholder groups: health care providers, including providers serving high concentrations of patients and communities impacted by health disparities;~~,~~ health plan companies;~~,~~ consumers, including consumers representing groups who experience health disparities;~~,~~ employers or other health care purchasers;~~,~~ and state government. No one stakeholder group shall have a majority of the votes on any issue or hold extraordinary powers not granted to any other governance stakeholder.

Sec. 37. Minnesota Statutes 2014, section 144E.001, is amended by adding a subdivision to read:

Subd. 5h. **Community medical response emergency medical technician.** "Community medical response emergency medical technician" or "CEMT" means a person who is certified as an emergency medical technician, who is a member of a registered medical response unit under section 144E.275, and who meets the requirements for additional certification as a CEMT as specified in section 144E.275, subdivision 7.

Sec. 38. Minnesota Statutes 2014, section 144E.275, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, the following definitions apply:

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Sec. 11. Minnesota Statutes 2014, section 144E.001, is amended by adding a subdivision to read:

Subd. 5h. **Community medical response emergency medical technician.** "Community medical response emergency medical technician" or "CEMT" means a person who is certified as an emergency medical technician, who is a member of a registered medical response unit under this chapter, and who meets the requirements for additional certification as a CEMT as specified in section 144E.275, subdivision 7.

Sec. 12. Minnesota Statutes 2014, section 144E.275, subdivision 1, is amended to read:

Subdivision 1. **Definition.** For purposes of this section, the following definitions apply:

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(a) "Medical response unit" means an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service. Medical response units may also provide CEMT services as permitted under subdivision 7.

(b) "Specialized medical response unit" means an organized service recognized by a board-approved authority other than a local political subdivision that responds to medical emergencies as needed or as required by local procedure or protocol.

Sec. 39. Minnesota Statutes 2014, section 144E.275, is amended by adding a subdivision to read:

Subd. 7. **Community medical response emergency medical technician.** (a) To be eligible for certification by the board as a CEMT, an individual shall:

(1) be currently certified as an EMT or AEMT;

(2) have two years of service as an EMT or AEMT;

(3) be a member of a registered medical response unit as defined under this section;

(4) successfully complete a CEMT training program from a college or university that has been approved by the board or accredited by a board-approved national accrediting organization. The training must include clinical experience under the supervision of the medical response unit medical director, an advanced practice registered nurse, a physician assistant, or a public health nurse operating under the direct authority of a local unit of government;

(5) successfully complete a training program that includes training in providing culturally appropriate care; and

(6) complete a board-approved application form.

(b) A CEMT must practice in accordance with protocols and supervisory standards established by the medical response unit medical director in accordance with section 144E.265.

(c) A CEMT may provide services within the CEMT skill set as approved by the medical response unit medical director.

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(a) "Medical response unit" means an organized service recognized by a local political subdivision whose primary responsibility is to respond to medical emergencies to provide initial medical care before the arrival of a licensed ambulance service. Medical response units may, subject to requirements specified elsewhere in this chapter and only when requested by the patient's primary physician, advanced practice registered nurse, physician assistant, or care team, provide, at the direction of a medical director, episodic population health support, episodic individual patient education, and prevention education programs.

(b) "Specialized medical response unit" means an organized service recognized by a board-approved authority other than a local political subdivision that responds to medical emergencies as needed or as required by local procedure or protocol.

Sec. 13. Minnesota Statutes 2014, section 144E.275, is amended by adding a subdivision to read:

Subd. 7. **Community medical response emergency medical technician.** (a) To be eligible for certification by the board as a CEMT, an individual shall:

(1) be currently certified as an EMT or AEMT;

(2) have two years of service as an EMT or AEMT;

(3) be a member of a registered medical response unit as defined in this chapter;

(4) successfully complete a CEMT training program from a college or university that has been approved by the board or accredited by a board-approved national accrediting organization. The training must include clinical experience under the supervision of the medical response unit medical director, an advanced practice registered nurse, a physician assistant, or a public health nurse operating under the direct authority of a local unit of government; and

(5) complete a board-approved application form.

(b) A CEMT must practice in accordance with protocols and supervisory standards established by the medical response unit medical director in accordance with section 144E.265.

(c) A CEMT may provide services as approved by the medical response unit medical director.

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(d) A CEMT may provide episodic individual patient education and prevention education but only as directed by a patient care plan developed by the patient's primary physician, an advanced practice registered nurse, or a physician assistant, in conjunction with the medical response unit medical director and relevant local health care providers. The patient care plan must ensure that the services provided by the CEMT are consistent with services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(e) A CEMT is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMTs under this chapter.

(f) A CEMT may not provide services as defined in section 144A.471, subdivisions 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

(1) take a regularly scheduled medication, but not to provide or bring the patient medication; and

(2) follow regularly scheduled treatment or exercise plans.

Sec. 40. Minnesota Statutes 2014, section 151.58, subdivision 2, is amended to read:

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

(a) "Automated drug distribution system" or "system" means a mechanical system approved by the board that performs operations or activities, other than compounding or administration, related to the storage, packaging, or dispensing of drugs, and collects, controls, and maintains all required transaction information and records.

(b) "Health care facility" means a nursing home licensed under section 144A.02; a housing with services establishment registered under section 144D.01, subdivision 4, in which a home provider licensed under chapter 144A is providing centralized storage of medications; a boarding care home licensed under sections 144.50 to 144.58 that is providing centralized storage of medications; or a Minnesota sex offender program facility operated by the Department of Human Services.

(c) "Managing pharmacy" means a pharmacy licensed by the board that controls and is responsible for the operation of an automated drug distribution system.

Sec. 41. Minnesota Statutes 2014, section 151.58, subdivision 5, is amended to read:

Subd. 5. **Operation of automated drug distribution systems.** (a) The managing pharmacy and the pharmacist in charge are responsible for the operation of an automated drug distribution system.

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(d) A CEMT may provide episodic individual patient education and prevention education only as directed by a patient care plan developed by the patient's primary physician, an advanced practice registered nurse, or a physician assistant, in conjunction with the medical response unit medical director and relevant local health care providers. The care plan must ensure that the services provided by the CEMT are consistent with services offered by the patient's health care home, if one exists, that the patient receives the necessary services, and that there is no duplication of services to the patient.

(e) A CEMT is subject to all certification, disciplinary, complaint, and other regulatory requirements that apply to EMTs under this chapter.

(f) A CEMT may not provide services defined in section 144A.471, subdivisions 6 and 7, except a CEMT may provide verbal or visual reminders to the patient to:

(1) take a regularly scheduled medication, but not to provide or bring the patient medication; and

(2) follow regularly scheduled treatment or exercise plans.

ARTICLE 1, SECTIONS 3 AND 4.

Sec. 3. Minnesota Statutes 2014, section 151.58, subdivision 2, is amended to read:

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

(a) "Automated drug distribution system" or "system" means a mechanical system approved by the board that performs operations or activities, other than compounding or administration, related to the storage, packaging, or dispensing of drugs, and collects, controls, and maintains all required transaction information and records.

(b) "Health care facility" means a nursing home licensed under section 144A.02; a housing with services establishment registered under section 144D.01, subdivision 4, in which a home provider licensed under chapter 144A is providing centralized storage of medications; a boarding care home licensed under sections 144.50 to 144.58 that is providing centralized storage of medications; or a Minnesota sex offender program facility operated by the Department of Human Services.

(c) "Managing pharmacy" means a pharmacy licensed by the board that controls and is responsible for the operation of an automated drug distribution system.

Sec. 4. Minnesota Statutes 2014, section 151.58, subdivision 5, is amended to read:

Subd. 5. **Operation of automated drug distribution systems.** (a) The managing pharmacy and the pharmacist in charge are responsible for the operation of an automated drug distribution system.

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(b) Access to an automated drug distribution system must be limited to pharmacy and nonpharmacy personnel authorized to procure drugs from the system, except that field service technicians may access a system located in a health care facility for the purposes of servicing and maintaining it while being monitored either by the managing pharmacy, or a licensed nurse within the health care facility. In the case of an automated drug distribution system that is not physically located within a licensed pharmacy, access for the purpose of procuring drugs shall be limited to licensed nurses. Each person authorized to access the system must be assigned an individual specific access code. Alternatively, access to the system may be controlled through the use of biometric identification procedures. A policy specifying time access parameters, including time-outs, logoffs, and lockouts, must be in place.

(c) For the purposes of this section only, the requirements of section 151.215 are met if the following clauses are met:

(1) a pharmacist employed by and working at the managing pharmacy, or at a pharmacy that is acting as a central services pharmacy for the managing pharmacy, pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all prescription drug orders before any drug is distributed from the system to be administered to a patient. A pharmacy technician may perform data entry of prescription drug orders provided that a pharmacist certifies the accuracy of the data entry before the drug can be released from the automated drug distribution system. A pharmacist employed by and working at the managing pharmacy must certify the accuracy of the filling of any cassettes, canisters, or other containers that contain drugs that will be loaded into the automated drug distribution system, unless the filled cassettes, canisters, or containers have been provided by a repackager registered with the United States Food and Drug Administration and licensed by the board as a manufacturer; and

(2) when the automated drug dispensing system is located and used within the managing pharmacy, a pharmacist must personally supervise and take responsibility for all packaging and labeling associated with the use of an automated drug distribution system.

(d) Access to drugs when a pharmacist has not reviewed and approved the prescription drug order is permitted only when a formal and written decision to allow such access is issued by the pharmacy and the therapeutics committee or its equivalent. The committee must specify the patient care circumstances in which such access is allowed, the drugs that can be accessed, and the staff that are allowed to access the drugs.

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(b) Access to an automated drug distribution system must be limited to pharmacy and nonpharmacy personnel authorized to procure drugs from the system, except that field service technicians may access a system located in a health care facility for the purposes of servicing and maintaining it while being monitored either by the managing pharmacy, or a licensed nurse within the health care facility. In the case of an automated drug distribution system that is not physically located within a licensed pharmacy, access for the purpose of procuring drugs shall be limited to licensed nurses. Each person authorized to access the system must be assigned an individual specific access code. Alternatively, access to the system may be controlled through the use of biometric identification procedures. A policy specifying time access parameters, including time-outs, logoffs, and lockouts, must be in place.

(c) For the purposes of this section only, the requirements of section 151.215 are met if the following clauses are met:

(1) a pharmacist employed by and working at the managing pharmacy, or at a pharmacy that is acting as a central services pharmacy for the managing pharmacy, pursuant to Minnesota Rules, part 6800.4075, must review, interpret, and approve all prescription drug orders before any drug is distributed from the system to be administered to a patient. A pharmacy technician may perform data entry of prescription drug orders provided that a pharmacist certifies the accuracy of the data entry before the drug can be released from the automated drug distribution system. A pharmacist employed by and working at the managing pharmacy must certify the accuracy of the filling of any cassettes, canisters, or other containers that contain drugs that will be loaded into the automated drug distribution system, unless the filled cassettes, canisters, or containers have been provided by a repackager registered with the United States Food and Drug Administration and licensed by the board as a manufacturer; and

(2) when the automated drug dispensing system is located and used within the managing pharmacy, a pharmacist must personally supervise and take responsibility for all packaging and labeling associated with the use of an automated drug distribution system.

(d) Access to drugs when a pharmacist has not reviewed and approved the prescription drug order is permitted only when a formal and written decision to allow such access is issued by the pharmacy and the therapeutics committee or its equivalent. The committee must specify the patient care circumstances in which such access is allowed, the drugs that can be accessed, and the staff that are allowed to access the drugs.

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(e) In the case of an automated drug distribution system that does not utilize bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician, so long as the activity is continuously supervised, through a two-way audiovisual system by a pharmacist on duty within the managing pharmacy. In the case of an automated drug distribution system that utilizes bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician or a licensed nurse, provided that the managing pharmacy retains an electronic record of loading activities.

(f) The automated drug distribution system must be under the supervision of a pharmacist. The pharmacist is not required to be physically present at the site of the automated drug distribution system if the system is continuously monitored electronically by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the board must be continuously available to address any problems detected by the monitoring or to answer questions from the staff of the health care facility. The licensed pharmacy may be the managing pharmacy or a pharmacy which is acting as a central services pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

Sec. 42. Minnesota Statutes 2014, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine ~~consultations~~ services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine ~~consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation~~ in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine ~~consultations~~ services per ~~recipient~~ enrollee per calendar week. Telemedicine ~~consultations~~ services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

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(e) In the case of an automated drug distribution system that does not utilize bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician, so long as the activity is continuously supervised, through a two-way audiovisual system by a pharmacist on duty within the managing pharmacy. In the case of an automated drug distribution system that utilizes bar coding in the loading process, the loading of a system located in a health care facility may be performed by a pharmacy technician or a licensed nurse, provided that the managing pharmacy retains an electronic record of loading activities.

(f) The automated drug distribution system must be under the supervision of a pharmacist. The pharmacist is not required to be physically present at the site of the automated drug distribution system if the system is continuously monitored electronically by the managing pharmacy. A pharmacist on duty within a pharmacy licensed by the board must be continuously available to address any problems detected by the monitoring or to answer questions from the staff of the health care facility. The licensed pharmacy may be the managing pharmacy or a pharmacy which is acting as a central services pharmacy, pursuant to Minnesota Rules, part 6800.4075, for the managing pharmacy.

Sec. 22. Minnesota Statutes 2014, section 256B.0625, subdivision 3b, is amended to read:

Subd. 3b. **Telemedicine ~~consultations~~ services.** (a) Medical assistance covers medically necessary services and consultations delivered by a licensed health care provider via telemedicine ~~consultations. Telemedicine consultations must be made via two-way, interactive video or store-and-forward technology. Store-and-forward technology includes telemedicine consultations that do not occur in real time via synchronous transmissions, and that do not require a face-to-face encounter with the patient for all or any part of any such telemedicine consultation. The patient record must include a written opinion from the consulting physician providing the telemedicine consultation. A communication between two physicians that consists solely of a telephone conversation is not a telemedicine consultation~~ in the same manner as if the service or consultation was delivered in person. Coverage is limited to three telemedicine ~~consultations~~ services per ~~recipient~~ enrollee per calendar week. Telemedicine ~~consultations~~ services shall be paid at the full allowable rate.

(b) The commissioner shall establish criteria that a health care provider must attest to in order to demonstrate the safety or efficacy of delivering a particular service via telemedicine. The attestation may include that the health care provider:

(1) has identified the categories or types of services the health care provider will provide via telemedicine;

(2) has written policies and procedures specific to telemedicine services that are regularly reviewed and updated;

(3) has policies and procedures that adequately address patient safety before, during, and after the telemedicine service is rendered;

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(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, part 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) If a health care provider provides the facility used as the originating site for the delivery of telemedicine to a patient, the commissioner shall make a facility fee payment to the originating site health care provider in an amount equivalent to the originated site fee paid by Medicare. No facility fee shall be paid to a health care provider that is being paid under a cost-based methodology or if Medicare has already paid the facility fee for an enrollee who is dually eligible for Medicare and medical assistance.

(e) For purposes of this subdivision, "telemedicine" is defined under section 62A.671, subdivision 9; "licensed health care provider" is defined under section 62A.671, subdivision 6; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

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(4) has established protocols addressing how and when to discontinue telemedicine services; and

(5) has an established quality assurance process related to telemedicine services.

(c) As a condition of payment, a licensed health care provider must document each occurrence of a health service provided by telemedicine to a medical assistance enrollee. Health care service records for services provided by telemedicine must meet the requirements set forth in Minnesota Rules, chapter 9505.2175, subparts 1 and 2, and must document:

(1) the type of service provided by telemedicine;

(2) the time the service began and the time the service ended, including an a.m. and p.m. designation;

(3) documentation of the licensed health care provider's basis for determining that telemedicine is an appropriate and effective means for delivering the service to the enrollee;

(4) the mode of transmission of the telemedicine service and records evidencing that a particular mode of transmission was utilized;

(5) the location of the originating site and the distant site;

(6) if the claim for payment is based on a physician's telemedicine consultation with another physician, the written opinion from the consulting physician providing the telemedicine consultation; and

(7) documentation of compliance with the criteria attested to by the health care provider in accordance with paragraph (b).

(d) If a health care provider provides the facility used as the originating site for the delivery of telemedicine to a patient, the commissioner shall make a facility fee payment to the originating site health care provider in an amount equivalent to the originated site fee paid by Medicare. No facility fee shall be paid to a health care provider that is being paid under a cost-based methodology or if Medicare has already paid the facility fee for an enrollee who is dually eligible for Medicare and medical assistance.

(e) For purposes of this subdivision, "telemedicine" is defined under section 62A.671, subdivision 9; "licensed health care provider" is defined under section 62A.671, subdivision 6; "health care provider" is defined under section 62A.671, subdivision 3; and "originating site" is defined under section 62A.671, subdivision 7.

(f) The criteria described in section 256B.0625, subdivision 3b, paragraph (b), shall not apply to managed care organizations and county-based purchasing plans, which may establish criteria as described in section 62A.672, subdivision 1, paragraph (b), clause (2), for the coverage of telemedicine services.

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312.17 **EFFECTIVE DATE.** This section is effective January 1, 2016.

312.18 Sec. 43. Minnesota Statutes 2014, section 256B.0625, subdivision 13, is amended to
312.19 read:

312.20 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
312.21 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
312.22 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
312.23 program as a dispensing physician, or by a physician, physician assistant, or a nurse
312.24 practitioner employed by or under contract with a community health board as defined in
312.25 section 145A.02, subdivision 5, for the purposes of communicable disease control.

312.26 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
312.27 unless authorized by the commissioner.

312.28 (c) For the purpose of this subdivision and subdivision 13d, an "active
312.29 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug
312.30 and when used in the manufacturing, processing, or packaging of a drug becomes an
312.31 active ingredient of the drug product. An "excipient" is defined as an inert substance
312.32 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active
312.33 pharmaceutical ingredients and excipients which are included in the medical assistance
312.34 formulary. Medical assistance covers selected active pharmaceutical ingredients and
313.1 excipients used in compounded prescriptions when the compounded combination is
313.2 specifically approved by the commissioner or when a commercially available product:

313.3 (1) is not a therapeutic option for the patient;

313.4 (2) does not exist in the same combination of active ingredients in the same strengths
313.5 as the compounded prescription; and

313.6 (3) cannot be used in place of the active pharmaceutical ingredient in the
313.7 compounded prescription.

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197.9 **EFFECTIVE DATE.** This section is effective January 1, 2017, and applies to
197.10 coverage offered, sold, issued, or renewed on or after that date.

ARTICLE 1, SECTIONS 9 AND 10.

12.21 Sec. 9. Minnesota Statutes 2014, section 256B.0625, subdivision 13, is amended to read:

12.22 Subd. 13. **Drugs.** (a) Medical assistance covers drugs, except for fertility drugs
12.23 when specifically used to enhance fertility, if prescribed by a licensed practitioner and
12.24 dispensed by a licensed pharmacist, by a physician enrolled in the medical assistance
12.25 program as a dispensing physician, or by a physician, physician assistant, or a nurse
12.26 practitioner employed by or under contract with a community health board as defined in
12.27 section 145A.02, subdivision 5, for the purposes of communicable disease control.

12.28 (b) The dispensed quantity of a prescription drug must not exceed a 34-day supply,
12.29 unless authorized by the commissioner.

12.30 (c) For the purpose of this subdivision and subdivision 13d, an "active
12.31 pharmaceutical ingredient" is defined as a substance that is represented for use in a drug
12.32 and when used in the manufacturing, processing, or packaging of a drug becomes an
12.33 active ingredient of the drug product. An "excipient" is defined as an inert substance
12.34 used as a diluent or vehicle for a drug. The commissioner shall establish a list of active
12.35 pharmaceutical ingredients and excipients which are included in the medical assistance
13.1 formulary. Medical assistance covers selected active pharmaceutical ingredients and
13.2 excipients used in compounded prescriptions when the compounded combination is
13.3 specifically approved by the commissioner or when a commercially available product:

13.4 (1) is not a therapeutic option for the patient;

13.5 (2) does not exist in the same combination of active ingredients in the same strengths
13.6 as the compounded prescription; and

13.7 (3) cannot be used in place of the active pharmaceutical ingredient in the
13.8 compounded prescription.

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(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the ~~lower~~ lowest of: (1) the number of dosage units contained in the manufacturer's original package; ~~and~~ (2) the number of dosage units required to complete the patient's course of therapy; or (3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Sec. 44. Minnesota Statutes 2014, section 256B.0625, subdivision 13e, is amended to read:

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(d) Medical assistance covers the following over-the-counter drugs when prescribed by a licensed practitioner or by a licensed pharmacist who meets standards established by the commissioner, in consultation with the board of pharmacy: antacids, acetaminophen, family planning products, aspirin, insulin, products for the treatment of lice, vitamins for adults with documented vitamin deficiencies, vitamins for children under the age of seven and pregnant or nursing women, and any other over-the-counter drug identified by the commissioner, in consultation with the formulary committee, as necessary, appropriate, and cost-effective for the treatment of certain specified chronic diseases, conditions, or disorders, and this determination shall not be subject to the requirements of chapter 14. A pharmacist may prescribe over-the-counter medications as provided under this paragraph for purposes of receiving reimbursement under Medicaid. When prescribing over-the-counter drugs under this paragraph, licensed pharmacists must consult with the recipient to determine necessity, provide drug counseling, review drug therapy for potential adverse interactions, and make referrals as needed to other health care professionals. Over-the-counter medications must be dispensed in a quantity that is the ~~lower~~ lowest of:

(1) the number of dosage units contained in the manufacturer's original package; ~~and~~

(2) the number of dosage units required to complete the patient's course of therapy; or

(3) if applicable, the number of dosage units dispensed from a system using retrospective billing, as provided under subdivision 13e, paragraph (b).

(e) Effective January 1, 2006, medical assistance shall not cover drugs that are coverable under Medicare Part D as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-2(e), for individuals eligible for drug coverage as defined in the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Public Law 108-173, section 1860D-1(a)(3)(A). For these individuals, medical assistance may cover drugs from the drug classes listed in United States Code, title 42, section 1396r-8(d)(2), subject to this subdivision and subdivisions 13a to 13g, except that drugs listed in United States Code, title 42, section 1396r-8(d)(2)(E), shall not be covered.

(f) Medical assistance covers drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B covered entities and ambulatory pharmacies under common ownership of the 340B covered entity. Medical assistance does not cover drugs acquired through the federal 340B Drug Pricing Program and dispensed by 340B contract pharmacies.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Sec. 10. Minnesota Statutes 2014, section 256B.0625, subdivision 13e, is amended to read:

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Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for legend prescription drugs, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. The pharmacy dispensing fee for over the counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescription drugs dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period not less than one calendar month or 30 days.

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Subd. 13e. **Payment rates.** (a) The basis for determining the amount of payment shall be the lower of the actual acquisition costs of the drugs or the maximum allowable cost by the commissioner plus the fixed dispensing fee; or the usual and customary price charged to the public. The amount of payment basis must be reduced to reflect all discount amounts applied to the charge by any provider/insurer agreement or contract for submitted charges to medical assistance programs. The net submitted charge may not be greater than the patient liability for the service. The pharmacy dispensing fee shall be $3.65 for legend prescription drugs, except that the dispensing fee for intravenous solutions which must be compounded by the pharmacist shall be $8 per bag, $14 per bag for cancer chemotherapy products, and $30 per bag for total parenteral nutritional products dispensed in one liter quantities, or $44 per bag for total parenteral nutritional products dispensed in quantities greater than one liter. The pharmacy dispensing fee for over-the-counter drugs shall be $3.65, except that the fee shall be $1.31 for retrospectively billing pharmacies when billing for quantities less than the number of units contained in the manufacturer's original package. Actual acquisition cost includes quantity and other special discounts except time and cash discounts. The actual acquisition cost of a drug shall be estimated by the commissioner at wholesale acquisition cost plus four percent for independently owned pharmacies located in a designated rural area within Minnesota, and at wholesale acquisition cost plus two percent for all other pharmacies. A pharmacy is "independently owned" if it is one of four or fewer pharmacies under the same ownership nationally. A "designated rural area" means an area defined as a small rural area or isolated rural area according to the four-category classification of the Rural Urban Commuting Area system developed for the United States Health Resources and Services Administration. Effective January 1, 2014, the actual acquisition cost of a drug acquired through the federal 340B Drug Pricing Program shall be estimated by the commissioner at wholesale acquisition cost minus 40 percent. Wholesale acquisition cost is defined as the manufacturer's list price for a drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which information is available, as reported in wholesale price guides or other publications of drug or biological pricing data. The maximum allowable cost of a multisource drug may be set by the commissioner and it shall be comparable to, but no higher than, the maximum amount paid by other third-party payors in this state who have maximum allowable cost programs. Establishment of the amount of payment for drugs shall not be subject to the requirements of the Administrative Procedure Act.

(b) Pharmacies dispensing prescriptions to residents of long-term care facilities using an automated drug distribution system meeting the requirements of section 151.58, or a packaging system meeting the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse, may employ retrospective billing for prescriptions dispensed to long-term care facility residents. A retrospectively billing pharmacy must submit a claim only for the quantity of medication used by the enrolled recipient during the defined billing period. A retrospectively billing pharmacy must use a billing period of not less than one calendar month or 30 days.

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(c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. ~~The~~ A pharmacy provider ~~will be~~ using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, is required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

~~(c)~~ (d) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

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(c) An additional dispensing fee of $.30 may be added to the dispensing fee paid to pharmacists for legend drug prescriptions dispensed to residents of long-term care facilities when a unit dose blister card system, approved by the department, is used. Under this type of dispensing system, the pharmacist must dispense a 30-day supply of drug. The National Drug Code (NDC) from the drug container used to fill the blister card must be identified on the claim to the department. The unit dose blister card containing the drug must meet the packaging standards set forth in Minnesota Rules, part 6800.2700, that govern the return of unused drugs to the pharmacy for reuse. ~~The~~ A pharmacy provider using packaging that meets the standards set forth in Minnesota Rules, part 6800.2700, subpart 2, will be required to credit the department for the actual acquisition cost of all unused drugs that are eligible for reuse, unless the pharmacy is using retrospective billing. The commissioner may permit the drug clozapine to be dispensed in a quantity that is less than a 30-day supply.

~~(c)~~ (d) Whenever a maximum allowable cost has been set for a multisource drug, payment shall be the lower of the usual and customary price charged to the public or the maximum allowable cost established by the commissioner unless prior authorization for the brand name product has been granted according to the criteria established by the Drug Formulary Committee as required by subdivision 13f, paragraph (a), and the prescriber has indicated "dispense as written" on the prescription in a manner consistent with section 151.21, subdivision 2.

~~(d)~~ (e) The basis for determining the amount of payment for drugs administered in an outpatient setting shall be the lower of the usual and customary cost submitted by the provider, 106 percent of the average sales price as determined by the United States Department of Health and Human Services pursuant to title XVIII, section 1847a of the federal Social Security Act, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. If average sales price is unavailable, the amount of payment must be lower of the usual and customary cost submitted by the provider, the wholesale acquisition cost, the specialty pharmacy rate, or the maximum allowable cost set by the commissioner. Effective January 1, 2014, the commissioner shall discount the payment rate for drugs obtained through the federal 340B Drug Pricing Program by 20 percent. The payment for drugs administered in an outpatient setting shall be made to the administering facility or practitioner. A retail or specialty pharmacy dispensing a drug for administration in an outpatient setting is not eligible for direct reimbursement.

Senate Language S1458-2

~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

~~(f)~~ (g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Sec. 45. Minnesota Statutes 2014, section 256B.072, is amended to read:

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.

House Language UES1458-1

~~(e)~~ (f) The commissioner may negotiate lower reimbursement rates for specialty pharmacy products than the rates specified in paragraph (a). The commissioner may require individuals enrolled in the health care programs administered by the department to obtain specialty pharmacy products from providers with whom the commissioner has negotiated lower reimbursement rates. Specialty pharmacy products are defined as those used by a small number of recipients or recipients with complex and chronic diseases that require expensive and challenging drug regimens. Examples of these conditions include, but are not limited to: multiple sclerosis, HIV/AIDS, transplantation, hepatitis C, growth hormone deficiency, Crohn's Disease, rheumatoid arthritis, and certain forms of cancer. Specialty pharmaceutical products include injectable and infusion therapies, biotechnology drugs, antihemophilic factor products, high-cost therapies, and therapies that require complex care. The commissioner shall consult with the formulary committee to develop a list of specialty pharmacy products subject to this paragraph. In consulting with the formulary committee in developing this list, the commissioner shall take into consideration the population served by specialty pharmacy products, the current delivery system and standard of care in the state, and access to care issues. The commissioner shall have the discretion to adjust the reimbursement rate to prevent access to care issues.

~~(f)~~ (g) Home infusion therapy services provided by home infusion therapy pharmacies must be paid at rates according to subdivision 8d.

EFFECTIVE DATE. This section is effective January 1, 2016, or upon federal approval, whichever is later.

Senate Language S1458-2

House Language UES1458-1

(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.

(e) Performance measures must be stratified as provided under section 62U.02, subdivision 1, paragraph (b), and risk-adjusted as specified in section 62U.02, subdivision 3, paragraph (b).

Sec. 46. Minnesota Statutes 2014, section 256B.69, subdivision 6, is amended to read:

Subd. 6. **Service delivery.** (a) Each demonstration provider shall be responsible for the health care coordination for eligible individuals. Demonstration providers:

(1) shall authorize and arrange for the provision of all needed health services including but not limited to the full range of services listed in sections 256B.02, subdivision 8, and 256B.0625 in order to ensure appropriate health care is delivered to enrollees. Notwithstanding section 256B.0621, demonstration providers that provide nursing home and community-based services under this section shall provide relocation service coordination to enrolled persons age 65 and over;

(2) shall accept the prospective, per capita payment from the commissioner in return for the provision of comprehensive and coordinated health care services for eligible individuals enrolled in the program;

(3) may contract with other health care and social service practitioners to provide services to enrollees; and

(4) shall institute recipient grievance procedures according to the method established by the project, utilizing applicable requirements of chapter 62D. Disputes not resolved through this process shall be appealable to the commissioner as provided in subdivision 11.

(b) Demonstration providers must comply with the standards for claims settlement under section 72A.201, subdivisions 4, 5, 7, and 8, when contracting with other health care and social service practitioners to provide services to enrollees. A demonstration provider must pay a clean claim, as defined in Code of Federal Regulations, title 42, section 447.45(b), within 30 business days of the date of acceptance of the claim.

(c) Managed care plans and county-based purchasing plans must comply with chapter 62M and section 62Q.85.

EFFECTIVE DATE. This section is effective January 1, 2016.

Sec. 47. **PRESCRIPTION DRUG ADVISORY COUNCIL.**

The commissioner of health shall make the first appointments to the Prescription Drug Advisory Council established in Minnesota Statutes, section 62Q.85, subdivision 6, by October 2, 2015, and convene the first meeting by November 1, 2015. The council shall select a chair from among its members at the first meeting of the council.

EFFECTIVE DATE. This section is effective August 1, 2015.

Sec. 48. **PROPOSAL FOR CHILD PROTECTION FOCUSED "COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN" (CEMT) MODEL.**

Senate Language S1458-2

The commissioner shall develop a proposal for a pilot project to create a community-based support system that coordinates services between child protection services and community emergency medical technicians. This pilot project model shall be developed with the input of stakeholders that represent both child protection services and community emergency medical technicians. The model must be designed so that the collaborative effort results in increased safety for children and increased support for families. The pilot project model must be reviewed by the Task Force on the Protection of Children, and the commissioner shall make recommendations for the pilot project to the members of the legislative committees with primary jurisdiction over CEMT and child protection issues no later than January 15, 2016.

Sec. 49. **COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.**

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, public health nurses, community health workers, the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters Association, the Minnesota State Firefighters Department Association, Minnesota Academy of Family Physicians, Minnesota Licensed Practical Nurses Association, Minnesota Nurses Association, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community medical response emergency medical technicians certified under Minnesota Statutes, section 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes, section 256B.0625. Services must be in the CEMT skill set and may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use.

(b) In order to be eligible for payment, services provided by a community medical response emergency medical technician must be:

(1) ordered by a medical response unit medical director;

(2) part of a patient care plan that has been developed in coordination with the patient's primary physician, advanced practice registered nurse, and relevant local health care providers; and

(3) billed by an eligible medical assistance enrolled provider that employs or contracts with the community medical response emergency medical technician.

In determining the community medical response emergency medical technician services to include under medical assistance coverage, the commissioner of human services shall consider the potential of hospital admittance and emergency room utilization reductions as well as increased access to quality care in rural communities.

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Sec. 23. **COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES COVERED UNDER THE MEDICAL ASSISTANCE PROGRAM.**

(a) The commissioner of human services, in consultation with representatives of emergency medical service providers, public health nurses, community health workers, the Minnesota State Fire Chiefs Association, the Minnesota Professional Firefighters Association, the Minnesota State Firefighters Department Association, Minnesota Academy of Family Physicians, Minnesota Licensed Practical Nurses Association, Minnesota Nurses Association, and local public health agencies, shall determine specified services and payment rates for these services to be performed by community medical response emergency medical technicians certified under Minnesota Statutes, section 144E.275, subdivision 7, and covered by medical assistance under Minnesota Statutes, section 256B.0625. Services may include interventions intended to prevent avoidable ambulance transportation or hospital emergency department use, care coordination, diagnosis-related patient education, and population-based preventive education.

(b) In order to be eligible for payment, services provided by a community medical response emergency medical technician must be:

(1) ordered by a medical response unit medical director;

(2) part of a patient care plan that has been developed in coordination with the patient's primary physician, advanced practice registered nurse, and relevant local health care providers; and

(3) billed by an eligible medical assistance-enrolled provider that employs or contracts with the community medical response emergency medical technician.

In determining the community medical response emergency medical technician services to include under medical assistance coverage, the commissioner of human services shall consider the potential of hospital admittance and emergency room utilization reductions as well as increased access to quality care in rural communities.

Senate Language S1458-2

(c) The commissioner of human services shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending by February 15, 2016. These services shall not be covered by medical assistance until legislation providing coverage for the services is enacted in law.

Sec. 50. **EVALUATION OF COMMUNITY MEDICAL RESPONSE EMERGENCY MEDICAL TECHNICIAN SERVICES.**

If legislation is enacted to cover community medical response emergency medical technician services with medical assistance, the commissioner of human services shall evaluate the effect of medical assistance and MinnesotaCare coverage for those services on the cost and quality of care under those programs and the coordination of those services with the health care home services. The commissioner shall present findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and spending by December 1, 2017. The commissioner shall require medical assistance and MinnesotaCare enrolled providers that employ or contract with community medical response emergency medical technicians to provide to the commissioner, in the form and manner specified by the commissioner, the utilization, cost, and quality data necessary to conduct this evaluation.

Sec. 51. **REVISOR INSTRUCTION.**

The revisor of statutes shall change "sections 62M.01 to 62M.16" to "sections 62M.01 to 62M.17" wherever the term appears in Minnesota Statutes, chapter 62M.

EFFECTIVE DATE. This section is effective August 1, 2015.

House Language UES1458-1

(c) The commissioner of human services shall submit the list of services to be covered by medical assistance to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by February 15, 2016. These services shall not be covered by medical assistance until legislation providing coverage for the services is enacted in law.

Sec. 24. **EVALUATION OF COMMUNITY ADVANCED EMERGENCY MEDICAL TECHNICIAN SERVICES.**

If legislation is enacted to cover community advanced emergency medical technician services with medical assistance, the commissioner of human services shall evaluate the effect of medical assistance and MinnesotaCare coverage for those services on the cost and quality of care under those programs and the coordination of those services with the health care home services. The commissioner shall present findings to the chairs and ranking minority members of the legislative committees with jurisdiction over health and human services policy and finance by December 1, 2017. The commissioner shall require medical assistance- and MinnesotaCare-enrolled providers that employ or contract with community medical response emergency medical technicians to provide to the commissioner, in the form and manner specified by the commissioner, the utilization, cost, and quality data necessary to conduct this evaluation.