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Ramsey County Civil, MN

STATE OF MINNESOTA | DISTRICT COURT

COUNTY OF RAMSEY | SECOND JUDICIAL DISTRICT
Case Type: Other Civil

Denise Walker and Brian Walker, wife and husband, on behalf of themselves and other Minnesota taxpayers,

Plaintiffs,

v.

Lucinda Jesson, in her official capacity as Commissioner, Minnesota Department of Human Services,

Defendant.

Court File No.
Assigned Judge:

COMPLAINT

For their Complaint, plaintiffs state and allege as follows:

INTRODUCTION

1. This lawsuit seeks declaratory and injunctive relief to prevent the Department of Human Services, State of Minnesota (hereinafter "DHS") from using public funds to pay for non-therapeutic abortions performed on indigent women.

2. Article XI, Section I of the Minnesota Constitution states that "No money shall be paid out of the treasury of this state except in pursuance of an appropriation by law."

3. Minn. Stat. § 245.03, subd. 2, states that it is the duty of the Commissioner of the Minnesota Department of Human Services to "prevent the waste or unnecessary spending of public money."

4. In 1995, the Minnesota Supreme Court ruled that "the State cannot refuse to provide abortions to MA[1]/GAMC[2]-eligible women when the procedure is necessary for therapeutic reasons." *Doe v. Gomez*, 542 N.W.2d 17, 32 (Minn. 1995)(emphasis added).[3]

5. The Court's decision in *Doe v. Gomez* ("*Gomez*") authorizes DHS to appropriate funds for the purpose of providing therapeutic abortions for indigent women. *Gomez*, however, does not authorize DHS to pay for non-therapeutic abortions. The Court noted that:

> this court's decision will not permit any woman eligible for medical assistance to obtain an abortion "on demand." Rather, under our interpretation of the Minnesota Constitution's guaranteed right to privacy, the difficult decision whether to obtain a therapeutic abortion will not be made by the government, but will be left to the woman and her doctor.

Gomez, 542 N.W.2d at 32.

6. Plaintiffs allege that DHS is funding non-therapeutic abortions on indigent women, in violation of the *Gomez* injunction and without any authorizing appropriation. As set out below, this allegation is based on data obtained from DHS and the Minnesota Department of Health ("MDH"), including data detailing the justifications cited for abortions paid for with public funds.

7. Plaintiffs allege, therefore, that DHS is violating Article XI, Section I of the Minnesota Constitution and Minn. Stat. § 245.03, subd.2, by paying for services, specifically non-therapeutic abortions for indigent women, without an appropriation by law. Plaintiffs seek relief on behalf of all similarly situated Minnesota taxpayers from Defendant's waste and unauthorized expenditure of state funds.

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[1] Medical Assistance.
[2] General Assistance Medical Care.
[3] *See also Gomez*, 542 N.W.2d at 19 (emphasis added):

> Our decision is only based upon this court's determination that a pregnant woman, who is eligible for medical assistance and is considering an abortion for therapeutic reasons, cannot be coerced into choosing childbirth over abortion by a legislated funding policy.

PARTIES

8. Plaintiff Denise Walker is a resident of Minnesota who pays taxes to the State of Minnesota. Plaintiff Brian Walker is a resident of Minnesota who pays taxes to the State of Minnesota. Denise Walker and Brian Walker are wife and husband.

9. Plaintiffs bring this action on behalf of themselves and other Minnesota taxpayers similarly situated.

10. Defendant Lucinda Jesson (the "Commissioner") is being sued in her official capacity as Commissioner of the Minnesota Department of Human Services. The Commissioner is charged with the oversight of DHS disbursements of governmental funds for, among other things, health care for indigent individuals.

JURISDICTION AND VENUE

11. This action is brought under Article XI, Section I of the Constitution of the State of Minnesota. Plaintiffs are Minnesota taxpayers seeking to restrain the unlawful disbursement of public funds, and bring this action on behalf of other Minnesota taxpayers similarly situated.

12. Venue is proper in this district under Minn. Stat. §§ 542.03 and 542.09.

FACTS

13. Minnesota Statutes delineate limitations on the public funding of abortions. Minn. Stat. §§ 256B.011, 256B.02, 256B.0625, subd. 16, 256B.40, 261.28, and 393.07, subd. 11.

14. In 1995, the Minnesota Supreme Court ruled that certain of these statutory limitations were unconstitutional, holding "that the State cannot refuse to provide abortions to MA/GAMC-eligible women when the procedure is necessary for therapeutic reasons." *Gomez*, 542 N.W.2d at 32.

15. *Gomez* extended the public funding of abortions performed on indigent women to include therapeutic abortions, but did not change the status of non-therapeutic abortions as not qualified for public funding.

16. DHS expends public funds for abortions through MA/GAMC [4] and MinnesotaCare. DHS operates Minnesota Health Care Programs (MHCP). MHCP includes MA, codified at Minn. Stat. ch. 256B, County Relief of Poor, codified at Minn. Stat. ch. 261, and MinnesotaCare, codified at Minn. Stat. ch. 256L.

17. These two programs, MA and MinnesotaCare (collectively referred to herein as "Public Assistance") have, after *Gomez*, separate criteria for abortion coverage.

18. According to the DHS Provider Manual (the "Manual"), "Payment for induced abortions and abortion-related services provided to MA and GAMC recipients is available under the following conditions:

- The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by, or arising from the pregnancy itself that would, as certified by a physician, place the woman in danger of death unless the abortion is performed
- Pregnancy resulted from rape
- Pregnancy resulted from incest
- Abortion is being done for other health/therapeutic reasons.

19. According to the Office of the Legislative Auditor's Report #03-07, titled "Controlling Improper Payments in the Medical Assistance Program," the DHS undertakes medical reviews to determine the medical necessity of "a sample of inpatient hospital services." A true and correct copy of Report #03-07, pages 33-35, is attached hereto as Exhibit A and incorporated herein by reference.

[4] General Assistance Medical Care (GAMC) was terminated effective March 1, 2011 by the State of Minnesota's Medicaid expansion in conjunction with Governor Dayton's Executive Order 11-01 and the Federal Patient Protection and Affordable Care Act, Pub. L. No. 111-148.

20. Since the vast majority of abortions are performed in outpatient facilities, it appears that DHS does not have a process for reviewing the medical necessity of publicly funded abortions. On information and belief, DHS defers to the representations of the abortion providers, who have a direct pecuniary interest, in order to determine whether an induced abortion may be paid for with public funds.

21. The Minnesota Department of Health ("MDH") collects abortion data. Minn. Stat. §§ 145.4131 et seq. From the individual reports it collects, MDH issues annually the "Induced Abortions in Minnesota January – December [Year]: Report to the Legislature," (the "Official Report"). Currently available public statistics date from October 1998 through December 2011.

22. MDH compiles its Official Reports from data contained in the "Report of Induced Abortion" (the "MDH Form"), a form submitted to MDH by abortion providers for each abortion performed in Minnesota. A true and correct copy of a blank MDH Form is attached hereto as Exhibit B and incorporated herein by reference.

23. As required by Minn. Stat. § 145.4131, the MDH Form lists nine possible reasons for each abortion. The MDH Form instructs the abortion provider to check all reasons that apply. More than one reason may be selected. The statutorily designated reasons are listed at section 21, "Specific Reason for the Abortion," of the MDH Form. *See* Ex. B at 2. Those specific reasons are:

- ☐ Pregnancy was a result of rape,
- ☐ Pregnancy was a result of incest,
- ☐ Economic reasons,
- ☐ Does not want children at this time,
- ☐ Emotional health is at stake,
- ☐ Physical health is at stake,
- ☐ Will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues,
- ☐ Pregnancy resulted in fetal anomalies,
- ☐ Unknown or the woman refused to answer.

24. Based on the authority of the injunction issued by the Court in *Gomez*, DHS is authorized to expend public funds only for therapeutic abortions performed on indigent women.

25. The MDH Form includes reasons that are both therapeutic and non-therapeutic.

26. Plaintiffs allege that abortions performed for the following reasons, as listed on the MDH Form, could conceivably qualify as therapeutic within the scope of the *Gomez* injunction:

- ☐ Pregnancy was a result of rape,
- ☐ Pregnancy was a result of incest,
- ☐ Emotional health is at stake,
- ☐ Physical health is at stake,
- ☐ Will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues, and
- ☐ Pregnancy resulted in fetal anomalies.

27. Plaintiffs allege that abortions performed for the following reasons, as listed on the MDH Form, do **not** qualify as therapeutic within the scope of the *Gomez* injunction:

- ☐ Economic reasons,
- ☐ Does not want children at this time,
- ☐ Unknown or the woman refused to answer,
- ☐ Other stated reason.

28. According to the MDH Official Reports, 174,805 abortions were performed in Minnesota from January 1999 through December 2011. The MDH Official Reports indicate that, for the same time period, 47,095 of these abortions (or 26.9%) were paid for by "Public Assistance."

29. Plaintiff's counsel submitted an information request to MDH under the Minnesota Government Data Practices Act seeking the reasons listed for those abortions paid for by Public Assistance. In response to that request, MDH produced a spreadsheet titled "Induced Abortion in Minnesota, 1999 – 2011: Reason for Abortion*[5] where the procedure was paid for by Public

[5] *More than one reason may be selected by an individual patient.

Assistance." A true and correct copy of this spreadsheet is attached hereto as Exhibit C and incorporated herein by reference.

30. Of the 47,095 abortions paid by Public Assistance from January 1999 through December 2011, at most 10,044 abortions were performed for reasons that could qualify as therapeutic under *Gomez*.[6] Specifically:

Reason	**Number**
Pregnancy was a result of rape	389
Pregnancy was a result of incest	58
Emotional health is at stake	5,136
Physical health is at stake	3,922
Will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues	163
Pregnancy resulted in fetal anomalies	376
Total	**10,044**

See Exhibit C.

31. Because more than one reason may be selected by a provider completing the MDH Form, the number of actual therapeutic abortions may be overstated by the MDH data.

32. During that thirteen-year period, DHS paid for at least 37,051 abortions performed on indigent women for **non-therapeutic** reasons (47,095 publicly funded abortions minus 10,044 putatively therapeutic reasons). Less than 22% of the abortions paid for with public funds during this time period were authorized by the *Gomez* injunction.

33. According to the MDH data, for that same thirteen-year period (1999 thru 2011), the following non-therapeutic reasons were recorded for publicly funded abortions:

[6] Plaintiffs do not concede that all of these reasons qualify as therapeutic under the meaning of term as used in *Gomez*.

Reason	**Number**
Economic reasons	14,085
Does not want children at this time	24,556
Unknown or the woman refused to answer	10,412
Other stated reason	9,287
Total	**58,340**

34. DHS has been expending public funds *ultra vires*, without appropriation, in violation of Article XI, Section I, of the Minnesota Constitution by paying for over 37,000 non-therapeutic abortions performed on indigent women from 1999 through 2011.

35. The MDH Form is not the only state form that abortion providers are required to submit. DHS requires that abortion providers submit a "Medical Necessity Statement" in order to receive payment for these abortions from Public Assistance. A true and correct copy of a blank Medical Necessity Statement is attached hereto as Exhibit D and incorporated herein by reference.

36. The Medical Necessity Statement lists the following qualifying reasons for a publicly-funded abortion:

> 1. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed.
>
> 2. Pregnancy resulted from rape.
>
> 3. Pregnancy resulted from incest.
>
> 4. Abortion is being done for other health reasons.
>
> 5. Abortion is being done to prevent substantial and irreversible impairment of a major bodily function.
>
> 6. Continuation of the pregnancy would endanger the woman's life.

37. According to data provided by DHS, from 2006 through 2010, Minnesota taxpayers paid for 19,295 abortions for income-qualified women:

Year	**Number**
2006	3,937
2007	3,914
2008	3,754
2009	3,933
2010	3,757
Total	**19,295**

A true and correct copy of this Report is attached hereto as Exhibit E and incorporated herein by reference.

38. Of these taxpayer-funded abortions over that five-year period, the reason listed for 19,226 of these abortions (99.7%) was #4 "Abortion is being done for other health reasons."

39. The MDH data for the same five-year period indicates that 19,625 abortions were paid by Public Assistance, but only 3,007 (15.3%) of these publicly funded abortions were performed for reasons that could qualify as therapeutic under *Gomez*.

40. On information and belief, abortion providers are vastly overstating the number of publicly funded abortions being performed for "other health reasons," a situation which has been compounded by DHS' lack of meaningful review of the medical necessity of the abortions for which it has been paying. As a result, the majority of abortions that have been paid for with public funds since at least 1999 have been performed for non-therapeutic reasons and in violation of the *Gomez* injunction.

41. Despite the Court's holding in *Gomez* that "this court's decision will not permit any woman eligible for medical assistance to obtain an abortion 'on demand,'" that is precisely what has occurred, and continues to occur, in practice.

42. On information and belief, Minnesota spends approximately $1.5 million annually to fund abortions for indigent women.

43. Plaintiffs, as taxpayers, are aggrieved by this wasteful and excessive government spending.

44. Not only does DHS pay for too many abortions for indigent women, but also a disproportionate number of these abortions are performed on African American women.

45. According to 2010 U.S. Census data, African Americans comprise 5.4% of the total state population.

46. According to the MDH compilation of abortion data, from 1999 through 2011, Public Assistance paid for 19,152 abortions performed on African American women. Just over forty percent (40%) of publicly funded abortions were performed on African American women. A true and correct copy of this report is attached hereto as Exhibit F and incorporated herein by reference.

47. Plaintiffs, who are African Americans, are especially aggrieved that the effect of this *ultra vires* spending is to disproportionately inhibit the growth of the African American population in this state.

COUNT I

EXPENDING FUNDS WITHOUT APPROPRIATION

48. Plaintiffs reiterate the allegations contained in the above paragraphs as if fully set forth herein.

49. The State of Minnesota has never appropriated funds to cover non-therapeutic abortions.

50. Abortion funding for any reason other than a therapeutic reason falls outside the scope of the *Gomez* injunction. Any expenditure of public funds for a non-therapeutic abortion has

been made in violation of the *Gomez* injunction, and without an appropriation, in violation of Article XI, Section I of the Minnesota Constitution and Minn. Stat. §245.03, subd. 2(1).

51. On information and belief, DHS makes no independent review of whether an abortion that has been submitted to DHS for public funding was performed for a therapeutic reason.

52. From 1999 through 2011, DHS has expended public funds to pay for over 37,000 non-therapeutic abortions, without any authorizing appropriation. DHS has expended approximately $14.9 million in public funds *ultra vires* for such abortions, in violation of Article XI, Section I of the Minnesota Constitution and Minn. Stat. § 245.03, subd. 2(1).

53. Plaintiffs are entitled to declaratory relief under Minn. Stat. §§ 555.01 et seq. to halt these unconstitutional expenditures.

54. Plaintiffs are entitled to preliminary and permanent injunctive relief requiring DHS to correct and eliminate the unconstitutional expenditure of public funds for non-therapeutic abortions.

COUNT II

DECLARATORY JUDGMENT

55. Plaintiffs reiterate the allegations contained in the above paragraphs as if fully set forth herein.

56. In 1978, the State of Minnesota acted to limit public funding of abortion to certain narrow reasons. Minn. Stat. § 256B.0625, subd. 16. The Supreme Court in *Gomez* broadened the definition of "therapeutic," and required DHS to pay for therapeutic abortions for indigent women, enjoining the operation of § 245B.0625 to the extent it conflicted with the Court's holding.

57. The *Gomez* decision has proven unworkable in practice. The distinction between therapeutic abortions, that must be paid for with public funds, and non-therapeutic abortions, which are not authorized for public funding, is too difficult to apply. Its demonstrable effect is that tens of thousands of non-therapeutic abortions have been paid for by Public Assistance.

58. Plaintiffs are entitled to declaratory relief under Minn. Stat. §§ 555.01 et seq. to prevent this unconstitutional expenditure of State funds.

PRAYER FOR RELIEF

WHEREFORE, Plaintiffs pray for relief against Defendant and respectfully request of the Court the following:

A. Enter declaratory judgment establishing that the DHS has expended public funds for non-therapeutic abortions without an authorizing appropriation, in violation of Article XI, Section I of the Minnesota Constitution;

B. Issue preliminary and permanent injunctive relief requiring DHS to correct and eliminate the unconstitutional expenditure of public funds for non-therapeutic abortions;

C. Issue preliminary and permanent injunctive relief directing DHS to cease all public expenditures for abortions until DHS can demonstrate that public funds no longer will be expended for non-therapeutic abortions;

D. Direct DHS to conduct an accounting to ascertain the amounts paid to providers for reimbursement of non-therapeutic abortions, and further directing DHS to seek repayment of such unlawful payments from each such provider;

E. Dissolve the *Gomez* injunction because it has proven to be unworkable in practice;

F. Award Plaintiffs their attorney fees and costs; and

G. Award such other relief as the Court deems just and equitable.

Dated: November 27, 2012

s/Charles R Shreffler
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Counsel for Plaintiffs

ACKNOWLEDGMENT

The undersigned hereby acknowledges that costs, disbursements, and reasonable attorney and witness fees may be awarded, pursuant to Minn. Stat. § 549.211, to the party against whom the allegations in this pleading are asserted.

Dated: November 27, 2012

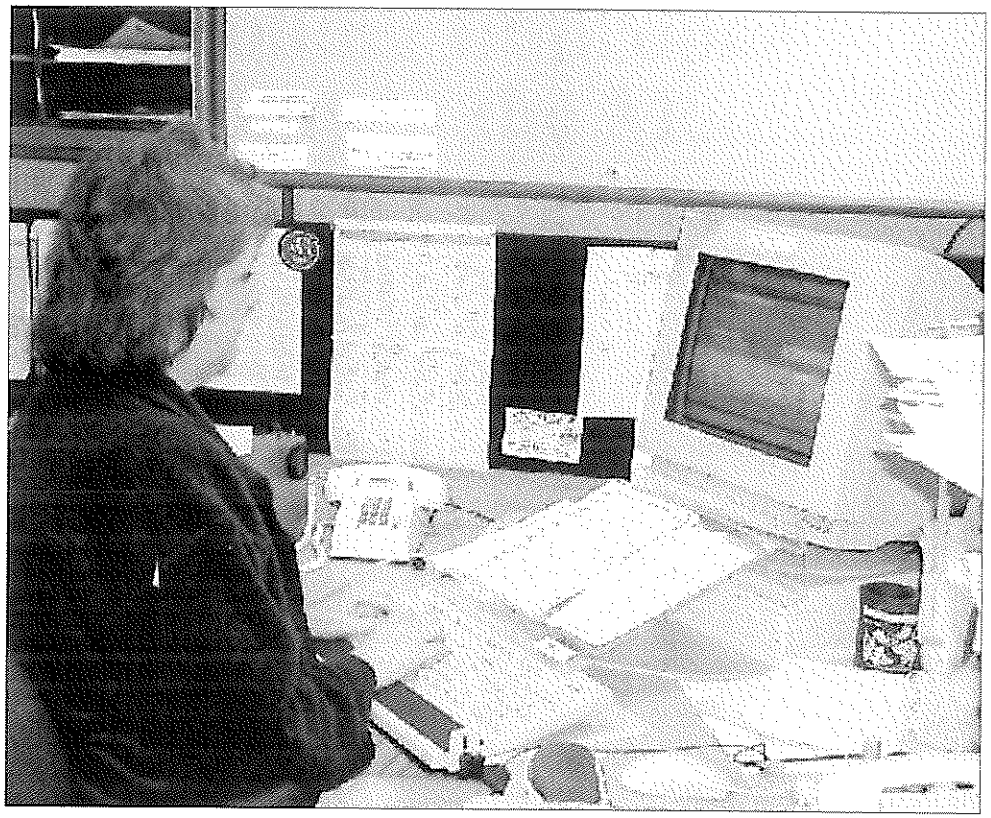
s/Charles R Shreffler
Charles R. Shreffler, #183295
Counsel for Plaintiffs

Report # 03-07

OFFICE OF THE LEGISLATIVE AUDITOR
STATE OF MINNESOTA

EVALUATION REPORT

Controlling Improper Payments in the Medical Assistance Program



AUGUST 2003

PROGRAM EVALUATION DIVISION
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658 Cedar Street - St. Paul, MN 55155
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E-mail: auditor@state.mn.us • Web Site: http://www.auditor.leg.state.mn.us

Exhibit A

OFFICE OF THE LEGISLATIVE AUDITOR
State of Minnesota • James Nobles, Legislative Auditor

August 20, 2003

Members
Legislative Audit Commission

The Medical Assistance (MA) program provides health care coverage to low income Minnesotans and costs over $4 billion annually, with the state and federal government splitting the cost. Given the size of this program and national concerns about fraud, abuse, and other improper payments in health care programs, the Legislative Audit Commission directed the Office of the Legislative Auditor to evaluate Minnesota's payment control strategy for MA. We began the evaluation in January of 2003.

While we found that Minnesota's approach to controlling improper MA payments is reasonable, the state's effort needs more focus, commitment, and coordination. Specifically, the Department of Human Services (DHS) should increase its efforts to (1) assess the size and nature of the improper payment problem in Minnesota, (2) evaluate how well its payment controls are working, and (3) coordinate its payment control activities. Our report provides a range of recommendations and options for improving the state's control efforts.

This report was researched and written by John Patterson (project manager), Valerie Bombach, and Dan Jacobson. We received the full cooperation of the Department of Human Services and the Attorney General's Office, the two state agencies responsible for controlling improper MA payments.

Sincerely,

/s/ James Nobles

James Nobles
Legislative Auditor

Room 140, 658 Cedar Street, St. Paul, Minnesota 55155-1603 • Tel: 651/296-4708 • Fax: 651/296-4712
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Table of Contents

Provider Training and Assistance

If providers understand MA policies and billing requirements, they are less likely to make billing mistakes. Consequently, Minnesota has an extensive program for training and assisting providers. As mentioned in Chapter 1, DHS' call-in help-desk took 236,854 telephone calls from providers in fiscal year 2002. In addition, DHS provides formal training sessions for providers throughout the state on various policies and billing procedures. In fiscal year 2002, DHS carried out 117 of these sessions with 2,080 providers attending.

DHS has been proactive in trying to address providers' billing questions and concerns.

In addition, DHS' provider training and assistance section has been proactive in providing useful information to providers. As mentioned earlier, the help-desk supervisor conducts a weekly training session for which he brings in people from different parts of DHS' health care system to update his staff on various policy and billing issues. Furthermore, the provider training unit conducts periodic focus groups of providers to proactively identify and address their concerns and questions.

Nevertheless, the director of the DHS' Performance Measurement and Quality Improvement Division told us that the department's provider training program could be improved. For instance, she said DHS should focus the training not only on how to complete and submit accurate claims but also on each provider's legal responsibility to thoroughly document its services and appropriately retain records. As mentioned earlier, the Office of the Inspector General of the U.S. Department of Health and Human Services released an audit in 2002 that revealed the need for this type of training. In the audit, the Office of the Inspector General reviewed 100 payments that DHS made for personal care services, and the Office of the Inspector General disqualified 33 of these payments largely because the agencies providing the services did not adequately document the services or retain appropriate records.[33]

Medical Reviews

Although DHS primarily uses medical reviews to control costs, they can also serve as a tool to prevent and detect fraud, abuse, and other types of improper activities, such as ordering excessive diagnostic tests or unnecessary hospital stays. However, because medical reviews can be subjective and are intertwined with the quality of medical care, establishing that a service is improper can sometimes be very difficult.

As described in Chapter 1, DHS contracts with Care Delivery Management Inc. (CDMI) to perform medical reviews, which determine the medical necessity, appropriateness, and quality of certain fee-for-service benefits. In addition, DHS' pharmacy services section performs it own reviews of prescriptions. Excluding some retrospective reviews, all these reviews are done before DHS pays the claim and, in some cases, before the service is provided.

---

33 Office of the Inspector General, *Audit of Medicaid Costs Claimed for Personal Care Services by the Minnesota Department of Human Services*.

When we compared Minnesota's medical review practices with those recommended in the payment control literature, we found that Minnesota has a strong framework, as shown in Table 2.3. For example:

- In fiscal year 2003, CDMI performed 19,000 inpatient hospital authorizations and about 8,000 concurrent and retrospective reviews of inpatient hospital services, which represented about 40 percent of the services provided.[34]

- DHS' pharmacy services section oversees and monitors the use of all pharmacy-related services through a system of computerized edits that verifies the appropriateness of prescriptions before they are filled. When a pharmacist is filling a prescription for an MA recipient, the pharmacist logs onto DHS' system and enters the prescription information. The computerized edits then compare the prescription with the recipient's benefit limits and other policy parameters—for example, prescription quantities and refill limits.

DHS conducts several important medical review procedures.

Table 2.3: Important Medical Review Procedures

Procedure	Minnesota Procedure
General Medical Reviews	
Carry out special authorizations for services that are outside of the standard benefits package	Yes
Carry out concurrent reviews that evaluate the appropriateness of services while they are being provided	Yes, for a sample of inpatient hospital services
Carry out retrospective reviews that evaluate the appropriateness of services after they provided	Yes, for a sample of inpatient hospital services
Make available to staff consultation services offered by medical professionals	Yes
Pharmaceutical Reviews	
Review the utilization of pharmaceuticals, which includes, among other things, identifying (1) pharmacists whose practices deviate from accepted medical standards, and (2) recipients who display drug-seeking behavior	Yes
Have a pharmacy benefits manager	Yes
Have a computerized edit system that checks the appropriateness of prescriptions while they are being filled	Yes, but system allows pharmacists to override some edits

SOURCES: We compiled these practices from several sources, including: Office of the Inspector General, U.S. Department of Health and Human Services, *Medicaid: Proactive Safeguards* (Chicago, IL: July 2000); Malcolm K. Sparrow, *Controlling Fraud and Abuse in Medicaid: Innovations and Obstacles* (A report from the Executive Seminars on Fraud and Abuse in Medicaid, sponsored by the Health Care Financing Administration) (Washington, DC: September 1999); and U.S. General Accounting Office, *Medicare: Program Activities Expanded, but Results Difficult to Measure* (Washington, DC: August 1999).

34 These figures include reviews for services provided under the state's General Assistance Medical Care and Minnesota Children With Special Health Needs programs.

- National studies recommend that Medicaid agencies have access to medical experts to help determine whether provider activities may constitute fraud, and CDMI provides medical consultation services upon request to DHS, although CDMI receives only a few of these requests annually.

- Finally, in at least one respect, Minnesota's practices exceed those found in some other states. In a recent review of eight states, the Office of the Inspector General of the U.S. Department of Health and Human Services found that only one state (Pennsylvania) conducted concurrent reviews of any kind, and its reviews were limited to mental health facility care.[35]

Medical reviews should be used selectively and in a cost-effective manner to prevent improper payments. For example, many states have indicated that requiring second opinions for medical procedures has not proven to be cost-effective and have abandoned this practice.[36]

Claims Processing

DHS has a high regard for the ability of its computerized claims processing system to identify and catch improper claims before they are paid. In general terms, the system makes sure that (1) the provider and recipient of the services are enrolled in the program, (2) the claim does not duplicate or conflict with other claims, and (3) the services are appropriately authorized and within the recipient's benefit limits. The system has roughly 1,000 computerized checks, which are referred to as "edits."

According to DHS, its claims processing "edits" have been praised by health insurance companies and other states.

While DHS does not have a current review or assessment demonstrating that its system is better than those used by other states and health insurers, the department points to complements that it has received.[37] For example, according to the supervisor of the claims processing section and the state's Medicaid director, some private insurers and companies that process Medicare claims in Minnesota say that DHS' claims processing edits are superior to their edits. In addition, DHS' staff report that when they attend national conferences, staff from other states praise DHS' edit system.

Even if the department's edit system is better than many others, we identified some claims processing practices recommended by payment control experts that Minnesota is not always following. Table 2.4 lists several state-of-the-art claims processing practices and indicates whether Minnesota follows them. Once again, we are not implying that DHS should adopt each of these practices; rather, the practices in Table 2.4 present an opportunity for the department to improve its prevention efforts. For example:

35 Office of the Inspector General, *Medicaid: Claims Processing Safeguards*, 10.

36 Office of the Inspector General, *Medicaid: Proactive Safeguards*, 14.

37 The claims processing edits are a part of the state's Medicaid Management Information System (MMIS). According to DHS, Minnesota received the highest score in the country (99.8) on its last *Federal Systems Performance Review*, which occurred back in 1997. DHS staff characterized the federal review as a "mini-recertification" of the state's MMIS. However, DHS was unable to provide us with a copy of this review.

REPORT OF INDUCED ABORTION

Center for Health Statistics
Minnesota Department of Health
85 East 7th Place, Box 64882
Saint Paul, MN 55164-0882
1-800-657-3900

1. Facility Reporting Code ☐☐☐☐

2. Physician Reporting Code ☐☐☐☐

3. Medical Specialty of the Physician Performing the Induced Abortion
☐ Obstetrics & Gynecology ☐ General/Family Practice
☐ Emergency Medicine
☐ Other *(Specify)* _____

4. Type of Admission
☐ Clinic ☐ Outpatient hospital ☐ Inpatient hospital ☐ Ambulatory surgery ☐ Other *(Specify)* _____

5. Patient Age at Last Birthday ☐☐ **6. Married** ☐ Yes ☐ No

7. Date of Pregnancy Termination ____/____/____
Month, Day, Year

8. Patient Residence
City: _____ County: _____
State: _____ Zip Code: ☐☐☐☐☐

9. Of Hispanic Origin
Specify No or Yes. If yes, specify, Cuban, Mexican, Puerto Rican, etc.
☐ No
☐ Yes
(Specify): _____

10. Race
☐ American Indian
☐ Asian
☐ Black
☐ White
☐ Other
(Specify): _____

11. Education
(Specify only highest grade completed)
☐☐ *Elementary/Secondary (0-12)*
☐☐ *College (1-4 or 5+)*

12. Date Last Normal Menses Began
☐☐ *Month,* ☐☐ *Day,* ☐☐ *Year*

13. Clinical Estimate of Gestation
☐☐ *(LMP Weeks)*

14. Previous Pregnancies *(Complete each section)*

Live Births		*Other Terminations*	
14a. Now Living	14b. Now Dead	14c. Spontaneous	14d. Induced *(Do not include this abortion)*
Number ☐☐	Number ☐☐	Number ☐☐	Number ☐☐
☐ None	☐ None	☐ None	☐ None

15. Contraceptive Use at Time of Conception

A. Use Status: *(Check only one)*
☐ Unknown - patient did not know if they used a method. ***(Do not fill out Part B.)***
☐ Never used any contraceptive method ***(Do not fill out Part B.)***
☐ Has used contraception, but not at the estimated time of conception. ***(Do not fill out Part B.)***
☐ Method used at time of conception. ***(Fill out PART B, METHOD USED.)***
☐ Patient did not provide information.

B. Method Used:
☐ Condoms
☐ Condoms & Spermicide
☐ Spermicide alone
☐ Sterilization (M)
☐ Sterilization (F)
☐ Injectable (Depo-Provera)
☐ IUD
☐ Mini Pills
☐ Combination Pills
☐ Diaphragm & Spermicide
☐ Diaphragm alone
☐ Cervical cap
☐ Rhythm/Natural Fam. Planning
☐ Fertility Awareness
☐ Withdrawal
☐ Other *(Specify)* _____

Exhibit B

16. Type of Abortion Procedure *(Check only one)*

- ☐ Suction Curettage
- ☐ Medical *(Nonsurgical)*,

  *Specify Medication(s)*_____ → *Does not include administration of morning after pills or post coital IUD insertion.*
- ☐ Dilation and Evacuation (D&E)
- ☐ Intra-Uterine Instillation (Saline or Prostaglandin)
- ☐ Hysterectomy/otomy
- ☐ Sharp Curretage (D&C)
- ☐ Induction of Labor (Pitocin, etc.)
- ☐ Intact Dilation and Extraction (D&X)
- ☐ Other Dilation and Extraction (D&X)
- ☐ Other *(Specify)* _____

17. Intraoperative Complication(s) from Induced Abortion

Complications that occur during and immediately following the procedure, before patient has left facility.
(Check all that apply)

- ☐ No complication(s)
- ☐ Cervical laceration requiring suture or repair
- ☐ Heavy bleeding/hemorrhage with estimated blood loss of ≥500cc
- ☐ Uterine perforation
- ☐ Other *(Specify)* _____

For post-operative complications, please refer to the REPORT OF COMPLICATION(S) FROM INDUCED ABORTION

18. Method of Disposal for Fetal Remains *(Check only one)*

☐ Cremation ☐ Interment by burial

19. Type of Payment *(Check only one)*

☐ Private coverage ☐ Public assistance health coverage ☐ Self pay

20. Type of Health Coverage *(Check only one)*

☐ Fee for service plan ☐ Capitated private plan ☐ Other/Unknown

21. Specific Reason for the Abortion *(Check all that apply)*

- ☐ Pregnancy was a result of rape
- ☐ Pregnancy was a result of incest
- ☐ Economic reasons
- ☐ Does not want children at this time
- ☐ Emotional health is at stake
- ☐ Physical health is at stake
- ☐ Will suffer substantial and irreversible impairment of major bodily function if the pregnancy continues
- ☐ Pregnancy resulted in fetal anomalies
- ☐ Unknown or the woman refused to answer
- ☐ Other _____

Center for Health Statistics
Minnesota Department of Health
85 East 7th Place, Box 64882
Saint Paul, MN 55164-0882
(800)657-3900

REPORT OF INDUCED ABORTION

Mandated reporters
All physicians or facilities that perform induced abortions by medical or surgical methods.

Induced abortion defined
For purpose of these reports, induced abortion means the purposeful interruption of an intrauterine pregnancy with the intention other than to produce a live-born infant, and which does not result in a live birth. This definition excludes management of prolonged retention of products of conception following fetal death.

Importance of induced abortion reporting
Reports of induced abortion are not legal records and are not maintained permanently in the files of the State office of vital statistics. However, the data they provide are very important from both a demographic and a public health viewpoint. Data from reports of induced abortion provide unique information on the characteristics of women having induced abortions. Uniform annual data of such quality are nowhere else available. Medical and health information is provided to evaluate risks associated with induced abortion at various lengths of gestation and by the type of abortion procedure used. Information on the characteristics of the women is used to evaluate the impact that induced abortion has on the birth rate, teenage pregnancy, and out-of-wedlock births. Because these abortion data provide information necessary to promote and monitor health, it is important that the reports be completed carefully.

Physician and patient confidentiality
According to MN Statutes §145.4134, the commissioner shall issue a public report providing statistics for the previous calendar year compiled from the data submitted under sections 145.4131 to 145.4133. Each report shall provide the statistics for all previous calendar years, adjusted to reflect any additional information from late or corrected reports. The commissioner shall ensure that none of the information included in the public reports can reasonably lead to identification of an individual having performed or having had an abortion. All data included on the forms under sections 145.4131 to 145.4133 must be included in the public report except that the commissioner shall maintain as confidential data which alone or in combination may constitute information from which, using epidemiologic principles, an individual having performed or having had an abortion may be identified. Service cannot be contingent upon a patient=s answering, or refusing to answer, questions on this form.

MINNESOTA STATE LAW

ARTICLE 10, HEALTH DATA REPORTING

§145.4131 [RECORDING AND REPORTING ABORTION DATA.] Subdivision 1. [FORMS.] (a) Within 90 days of the effective date of this section, the commissioner shall prepare a reporting form for use by physicians or facilities performing abortions. A copy of this section shall be attached to the form. A physician or facility performing an abortion shall obtain a form from the commissioner. (b) The form shall require the following information: (1) the number of abortions performed by the physician in the previous calendar year, reported by month; (2) the method used for each abortion; (3) the approximate gestational age expressed in one of the following increments: (i) less than nine weeks; (ii) nine to ten weeks; (iii) 11 to 12 weeks; (iv) 13 to 15 weeks; (v) 16 to 20 weeks; (vi) 21 to 24 weeks; (vii) 25 to 30 weeks; (viii) 31 to 36 weeks; or (ix) 37 weeks to term; (4) the age of the woman at the time the abortion was performed; (5) the specific reason for the abortion, including, but not limited to, the following: (i) the pregnancy was a result of rape; (ii) the pregnancy was a result of incest; (iii) economic reasons; (iv) the woman does not want children at this time; (v) the woman's emotional health is at stake; (vi) the woman's physical health is at stake; (vii) the woman will suffer substantial and irreversible impairment of a major bodily function if the pregnancy continues; (viii) the pregnancy resulted in fetal anomalies; or (ix) unknown or the woman refused to answer; (6) the number of prior induced abortions; (7) the number of prior spontaneous abortions; (8) whether the abortion was paid for by: (i) private coverage; (ii) public assistance health coverage; or (iii) self-pay; (9) whether coverage was under: (i) a fee-for-service plan; (ii) a capitated private plan; or (iii) other; (10) complications, if any, for each abortion and for the aftermath of each abortion. Space for a description of any complications shall be available on the form; and (11) the medical specialty of the physician performing the abortion. Subd. 2. SUBMISSION.] A physician performing an abortion or a facility at which an abortion is performed shall complete and submit the form to the commissioner no later than April 1 for abortions performed in the previous calendar year. The annual report to the commissioner shall include the methods used to dispose of fetal tissue and remains. Subd. 3. [ADDITIONAL REPORTING.] Nothing in this section shall be construed to preclude the voluntary or required submission of other reports or forms regarding abortions.

REPORTING PROCEDURE

COMPLETION AND SUBMISSION OF REPORTS

1. Reporting by physician or facility
The Minnesota Department of Health (MDH), Center for Health Statistics, encourages physicians and facilities to develop internal policies for the completion and submission of the Report of Induced Abortion. MDH recommends that these policies designate either the physician or the facility as having the overall responsibility and authority to see that the report is completed and filed on time. This may help prevent duplicate reporting and failure to report. If facilities take the responsibility to report on behalf of their physicians MDH suggests the following reporting procedure:

* Notify physicians that the facility will be reporting on their behalf.
* Call the Minnesota Center for Health Statistics for assignment of facility reporting codes and physician reporting codes (See instructions #2-3).
* Assign physician reporting codes to physicians and maintain a list of these assignments.
* Develop efficient procedures for prompt preparation and filing of the reports.
* Collect and record the information required by the report.
* Prepare a correct and legible report for each abortion performed.
* Submit the reports to the Minnesota Center for Health Statistics within the time specified by the law.
* Cooperate with the Minnesota Center for Health Statistics concerning queries on report entries.
* Call on the Minnesota Center for Health Statistics for advice and assistance when necessary.

If a facility decides not to report on behalf of their physicians, or for physicians who perform induced abortions outside a hospital, clinic, or other institution, the physician performing the abortion is responsible for obtaining a physician reporting code from MDH (See instruction #3), collecting all of the necessary data, completing the report, and filing it with the Minnesota Center for Health Statistics within the time period specified by law (See instruction #7).

2. Facility reporting codes
All facilities reporting on behalf of physicians must be assigned a reporting code from MDH. This code is in addition to individual physician reporting codes (See instruction #3). Facilities must submit a name and address to receive a facility code. For facilities that have been reporting to MDH prior to October 1, 1998, already have a facility reporting code and may continue to use the same code for future reporting.

3. Physician reporting codes
All physicians must be assigned a reporting code in order to submit a Report of Induced Abortion. Reports submitted without a physician reporting code will be considered incomplete. To obtain a code, physicians, or facilities reporting on behalf of physicians (See instruction # 1), must call MDH to be assigned one code per physician. MDH will require that a valid mailing address be provided for the purposes of keying the reporting code, but no other identifying information will be asked or accepted. Addresses provided may be a business address, or an address established by the physician or facility, such as a PO Box. If facilities are reporting on behalf of their physicians, the facility address may be used for the physician address.

4. One report per induced termination of pregnancy
Complete one report for each termination of pregnancy procedure performed.

5. Criterion for a complete report
All items on the report should have a response, even if the response is "0, "None," "Unknown," or "Refuse to Answer."

6. "Reason for abortion" question
MDH recommends that Item #21 on the report be reviewed with each patient. All responses can be reviewed with the patient before completing the question. If this question is transcribed to another piece of paper, or read to the patient, the question must be copied or read exactly as it is worded on the Report of Induced Abortion. If the patient does not complete the question because she refuses to answer, then the facility or physician must check the appropriate response, which is "Refuse to answer."

7. Method of disposal for fetal remains
Reporters should be informed that this question applies to disposal of fetal remains as defined under MN Statutes §145.1621, subd.2.

8. Submission dates
Reports should be completed and submitted to the Center for Health Statistics as soon as possible following each procedure. MDH encourages facilities and physicians to submit reports on a monthly basis, but the final date for submitting reports is April 1 of the following year (e.g., all reports for procedures done in 1998 are due by April 1, 1999). (MN Statutes 1998, §145.411)

Induced Abortion in Minnesota, 1999 - 2010
Reason for Abortion, Procedures Paid by Public Assistance

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total Paid by Public Assistance	2,741	2,680	3,112	3,526	3,822	3,949	3,849	3,969	3,961	3,865	3,946	3,884	3,791
Pregnancy was a result of rape	30	34	34	35	28	22	28	33	33	38	26	24	24
Pregnancy was a result of incest	1	4	2	7	4	2	2	4	5	8	5	4	10
Economic reasons	360	551	702	877	883	1,000	1,283	1,489	1,546	1,321	1,258	1,359	1,456
Does not want children at this time	743	1,112	1,405	1,452	1,416	1,569	2,245	2,380	2,681	2,614	2,301	2,241	2,397
Emotional health is at stake	260	314	420	500	621	606	583	261	314	335	243	312	367
Physical Health is at stake	211	258	329	370	520	469	407	232	263	235	187	224	217
Continued pregnancy will cause impairment of major bodily function	20	6	11	12	15	15	9	13	6	8	17	14	17
Pregnancy resulted in fetal anomalies	29	18	31	19	28	19	24	26	29	24	32	52	45
Unknown or the woman refused to answer	1,154	682	665	997	1,271	1,307	650	624	484	523	778	778	499
Other stated reason	571	565	643	557	646	678	822	818	812	741	813	814	807

Exhibit C

DHS-2327-ENG 5-08

Minnesota Department of Human Services

Minnesota Health Care Programs
Medical Necessity Statement

Section I. Patient Information

PATIENT'S NAME	RECIPIENT ID NUMBER	DATE OF PROCEDURE
STREET ADDRESS		
CITY	STATE	ZIP CODE

Section II. Physician Information

The abortion is being performed for the following reason: (please check only one)

- ☐ 1. The woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless the abortion is performed. (Applies to Medical Assistance and General Assistance.)
- ☐ 2. Pregnancy resulted from rape. (Applies to Medical Assistance, General Assistance, and MinnesotaCare.)
- ☐ 3. Pregnancy resulted from incest. (Applies to Medical Assistance, General Assistance, and MinnesotaCare.)
- ☐ 4. Abortion is being done for other health reasons. (Applies to Medical Assistance, and General Assistance.)
- ☐ 5. Abortion is being done to prevent substantial and irreversible impairment of a major bodily function. (Applies to MinnesotaCare only.)
- ☐ 6. Continuation of the pregnancy would endanger the woman's life. (Applies to MinnesotaCare only.)

PHYSICIAN'S NAME	NPI	
OFFICE STREET ADDRESS		
CITY	STATE	ZIP CODE
PHYSICIAN'S SIGNATURE		DATE

PO Box 64893 North • Saint Paul, Minnesota 55164

Exhibit D

Minnesota Health Care Programs - Abortion Provider Report Fee-For-Service Data Only Final - CY 2006 (All Quarters)	
Abortion Reason Code	**Count**
1	7
2	14
3	2
4	3914
Total	**3,937**

Minnesota Health Care Programs - Abortion Provider Report Fee-For-Service Data Only Final - CY 2007 (All Quarters)	
Abortion Reason Code	**Count**
2	9
3	2
4	3,903
Total	**3,914**

Minnesota Health Care Programs - Abortion Provider Report Fee-For-Service Data Only Final - CY 2008 (All Quarters)	
Abortion Reason Code	**Count**
1	1
2	11
3	2
4	3,740
Total	**3,754**

Minnesota Health Care Programs - Abortion Provider Report Fee-For-Service Data Only Final - CY 2009 (All Quarters)	
Abortion Reason Code	**Count**
1	3
2	4
3	1
4	3,925
Total	**3,933**

Minnesota Health Care Programs - Abortion Provider Report Fee-For-Service Data Only Final - CY 2010 (All Quarters)	
Abortion Reason Code	**Count**
2	9
3	4
4	3,744
	3,757

KEY

ABORTION REASON CODE:

1 ABORT CONSENT YES ENDANGER

2 ABORT CONSENT YES RAPE

3 ABORT CONSENT YES INCEST

4 ABORT CONSENT YES OTHER HLTH

5 ABORT CONSENT YES IMPAIRMENT

Exhibit E

Induced Abortion in Minnesota, 1999 - 2011

Race/Ethnicity of Patient for Procedures Paid by Public Assistance

	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Total Paid by Public Assistance	2,739	2,681	3,112	3,559	3,843	3,950	3,850	3,969	3,959	3,864	3,946	3,884	3,791
Race/Ethnicity													
White	1,087	1,064	1,370	1,635	1,747	1,788	1,711	1,716	1,648	1,654	1,624	1,653	1,456
African American	1,098	1,120	1,167	1,361	1,503	1,551	1,530	1,638	1,696	1,599	1,683	1,576	1,630
American Indian	135	142	174	179	191	159	167	141	175	172	203	197	182
Asian	258	195	217	189	186	174	178	154	155	170	168	168	154
Other	66	76	115	112	123	162	163	213	177	203	208	228	282
Race not Reported	95	84	69	83	93	116	101	107	108	66	60	62	87
Hispanic*	124	136	184	215	224	202	202	207	225	188	200	196	204

*may of be any of the above races

Exhibit F