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STATE OF MINNESOTA
DEPARTMENT OF HEALTH

In The Matter Of Proposed Rules Relating To Aggregate Provider Data - Chapter 4651

STATEMENT OF NEED AND REASONABLENESS

I. Statutory Authority.

The commissioner's general legal authority for adopting these rules is found in Minnesota Statutes, section 62J.35, subdivision 5, which states:

"**62J.35 DATA COLLECTION.**

Subdivision 1. **Data collection by commissioner.** For purposes of forecasting rates of growth in health care spending and setting limits under section 62J.04, subdivisions 1 and 1a, the commissioner may collect from health care providers data on patient revenues and health care spending received during a time period specified by the commissioner. The commissioner may also collect data on health care revenues and spending from group purchasers of health care. Health care providers and group purchasers doing business in the state shall provide the data requested by the commissioner at the times and in the form specified by the commissioner. Professional licensing boards and state agencies responsible for licensing, registering, or regulating providers shall cooperate fully with the commissioner in achieving compliance with the reporting requirements.

Subd. 5. **Rules.** The commissioner shall adopt permanent rules and may adopt emergency rules to implement the data collection and reporting requirements in this chapter. The commissioner may combine all data reporting and collection requirements into a unified process so as to minimize duplication and administrative costs."

Legislative authority for requiring data from health care providers is found in Minnesota Statutes, section 62J.41, subd. 1, which states:

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

(1) the total number of patients served;
(2) the total number of patients served by state of residence and Minnesota county;
(3) the site or sites where the health care provider provides services;
(4) the number of individuals employed, by type of employee, by the health care provider;
(5) the services and their costs for which no payment was received;

(6) total revenue by type of payer, including but not limited to, revenue from Medicare, Medical Assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients;

(7) revenue from research activities;

(8) revenue from educational activities;

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

(10) revenue from donations; and

(11) any other data required by the commissioner, including data in disaggregated form, for the purpose of developing spending estimates, setting spending limits, monitoring actual spending, and monitoring costs, and quality.

Specific references to other statutory authority will be given as appropriate in the general and part by part statement of need and reasonableness.

II. General Statement of Need and Reasonableness.

The proposed rules delineate the reporting requirements for health care provider financial and statistical data. The purpose of the proposed rules is to describe the data which needs to be reported annually to the commissioner and to describe who is required to report such data. The proposed rules specifically define the data elements to ensure that uniform and accurate data is reported. The proposed rules also include provisions for reporting dates, extensions, and review of reports.

A. Legislative History- Health Care Reform- MinnesotaCare Act- Data Collection Objectives

Minnesota's health care reform initiative encompasses a wide range of activities. The primary goal is to provide universal coverage for health care while maintaining the quality of the care and reducing the rate of growth in current health care expenditures. Cost containment was clearly a part of the 1992 MinnesotaCare Act and is the vehicle to achieve savings that could be used to expand coverage to the currently uninsured. The 1992 MinnesotaCare Act provided a framework for the overall approach to cost containment: the rate of growth in health care spending must be reduced by 10 percent each year beginning in 1993 and the Commissioner of Health was required to establish enforceable statewide and regional limits on the rate of growth of health care spending for Minnesota residents. The 1992 legislation established a 25-member commission (The Minnesota Health Care Commission) of providers, payers, and consumers to develop a cost containment strategy and report back to the Legislature in 1993. The Minnesota Health Care Commission met bimonthly for a period of six months to develop and report its cost containment strategy to the Legislature. The Commission's basic proposal, with some modification of the details, was passed by the Legislature as part of the 1993 MinnesotaCare Act.

The three key components of Minnesota's cost containment strategy include the following: 1) Integrated Service Networks (ISNs) that agree to provide a defined set of benefits for a fixed price; 2) the Regulated All-Payer Option (RAPO) that sets standardized payment rates for

payers and providers for services provided outside of the ISN system; and 3) overall limits on the rate of growth for health care expenditures for the State.

The framework underlying the strategy of expenditure limits chosen by the state of Minnesota requires that one be able to quantify state health care expenditures and monitor the expenditures and their trends over time. There is currently limited data available on health care spending at the state level. The federal Health Care Financing Administration (HCFA) publishes estimates on health care spending by state; once in 1982 and more recently in 1993. However, the method used by HCFA actuaries does not provide the detailed information needed to effectively implement and enforce spending limits at the state level. In addition, much of the work done in estimating state-level spending is developed by manually pulling together a diverse set of information from various data sources and this time-consuming compilation of disparate data sources must be re-enacted every year to keep the numbers up to date.

Minnesota's objective was to develop its own method and state infrastructure for collecting information on health care spending for the purposes of quantifying and monitoring health care expenditures and enforcing the limits on the rate of growth of that spending. State-level data would be more accurate, more timely, and could be tied to individual payers and provider groups for accountability purposes. In addition the data could be used to inform policy makers on the impact of health care reform.

The Health Care Commission recommended using a two stage strategy for data collection that included: (1) a short-term initiative to provide immediate information from payers on a significant, but not complete, picture of health care spending that will be used to establish a growth trend for 1991; and (2) a more comprehensive data collection plan to provide more detailed data based on aggregate surveys of providers and payers and encounter-level data that can be used to monitor spending and growth patterns over time. The framework for defining the elements to include in health care spending is based on the framework used by HCFA National Health Expenditure accounts to estimate national expenditures.

The short-term data collection strategy used to establish the 1991 baseline of health care expenditures clearly did not capture all health care expenditures of interest. The data did not represent all payers nor all types of health care expenditures. Other expenditures of interest that were not reviewed as part of the short-term strategy include out-of-pocket expenditures, charity care and bad debt, technology, research and education, and capital expenses. Several provider groups felt strongly that by relying on payer-level data to set expenditure limits, the Department would miss several important components, namely bad debt, charity care and out-of-pocket costs. In response, a physician-clinic survey was developed to supplement hospital financial information as part of the long-term data collection strategy.

The goal of the long-term data collection strategy was to collect aggregate data on health care revenues and expenditures by payer type and service category for all public and private payers. The state has several data sources that while not all-inclusive are helpful in building the process for data collection for other payers and providers. Minnesota has long-standing data collection requirements for aggregate financial data from hospitals and HMOs and

detailed information on its public programs. The largest gaps include the lack of information on services by medical doctors and services by other health care providers.

The data collection strategy involves collecting: 1) aggregate data on health care revenues and expenditures by payer type and service category for both public and private programs, and 2) disaggregated claims paid and encounter level data provided by payers. This data will be used to track total health care expenditures and revenues in the State of Minnesota. Attention will be given to the data collection and aggregation process to avoid any double counting. The two levels of data will be used to document revenues and expenditures and to cross check the data provided through each method. More detailed information will be needed for both the provider and payer groups including but not limited to the identification of Minnesota and non-Minnesota residents and the county of residence to be able to establish regional spending and growth targets.

Aggregate data from HMOs (and eventually ISNs) and hospitals will be based on modified versions of existing annual financial reporting forms.. New surveys were developed for commercial insurers, Blue Cross/Blue Shield, self-insured plans, and physician clinics.

In order to estimate and monitor health care spending in the State of Minnesota for the purposes of establishing spending limits more precise state-level data is needed. A primary objective has been to collect uniform and consistent state-level data in a routine and efficient manner on an ongoing basis. The Health Care Commission's report to the Legislature outlined the key assumptions for data collection. These include the following. Health care revenue and spending data will be routinely collected from both payers and providers of health care services. Data will be collected annually based on consistent guidelines and data definitions. The data set will include as a base, expenditures and revenues for health care services. The expenditure data base will be limited in the initial years but will evolve as additional sources of data are developed and submitted on either a voluntary basis or through legislative requirements. Data definitions and data collection techniques will be refined over time to ensure the collection of uniform and accurate data on health care spending and to assess the balance between the need for accurate data and the costs associated with collecting the data.

B. Uses of health care provider data.

1) Data will contribute to the development of estimates of total health care spending for the state of Minnesota.

The information collected as part of the data requirements for providers will be used to help establish baseline information on health care expenditures and track expenditures over time. The Department currently collects detailed revenue and cost data from hospitals. The hospital data set has allowed the Department of Health to monitor hospital expenditures and evaluate policy options that are being considered by the Minnesota legislature, the federal government, and by other state agencies.

There currently is no information routinely collected on health care spending in Minnesota from providers other than hospitals. Particularly lacking is information on health care spending for physician services. According to 1991 HCFA data personal health care spending totalled $660.2 billion, physician services account for 21.5 percent of personal health care spending, while hospitals account for 44 percent. (See table on National Health Expenditures, By Source of Funds And Type of Expenditure, Billions of Dollars, Calendar Year 1991, included with the SONAR as an appendix.) Obtaining data on physicians as well as chiropractors and dentists will allow the state to account for approximately 75 percent of personal health care spending based upon this national data.

Overall, the aggregate information from health care providers will provide baseline information on health care spending by type of provider and will allow the state to monitor those trends over time. Compiled with other health care spending data, this data will provide information for policy analysts and key decision makers on the total picture of health care spending. Some of the questions that will be addressed include the following:

a) What proportion of health care spending is attributed to physician services, and what proportion is attributed to hospital services?
b) How does this distribution of health care spending track with national trends for the same set of services?
c) How have the trends in health care spending changed over time?

2. The data collected will provide unique information that is not a part of other data collection requirements.

Collecting information directly from providers on health care revenues and costs will provide additional information that is not a part of the aggregate information submitted by payers. Payers are required to submit aggregate data on health care spending by type of provider. However, the information submitted is based on claims paid and will not include any expenditures that are not covered by third-party payers. This includes out-of-pocket payments made directly by the patient and care that is provided without remuneration. In addition, the state does not have the authority to require self-insured plans to submit aggregate data. Collecting data directly from the providers will provide this additional piece of data.

3. The data collected will provide needed information that will be used to refine the methodology used to estimate health care spending in the State of Minnesota that was used to set limits on the rate of growth of health care spending.

The 1993 MinnesotaCare Act established limits on the rate of growth of health care spending for the State of Minnesota. The limits were set in statute and all payers and providers are required to operate with the proposed constraints on total health care spending (Minnesota Statutes 62J.35, subd. 1). These growth limits were based on estimates of current spending in the State of Minnesota and trends in that spending. The information was based on a subset of data collected from payers for the years 1990 and 1991. Information was also

collected for 1992. The 1990-1991 information was used to set the baseline on health care spending and to forecast a 1994 trend rate. The data were based on an estimated 60-70% of total health care spending in the state.

Collecting additional data from payers and providers will provide a more complete picture of health care spending in the state. The data will be used to update the 1990-1992 information and will represent closer to 90% of the health care spending in the state. A more accurate picture of health care spending and trends will be used to refine the methodology used to forecast health care spending and set growth limits for the State of Minnesota.

4. Aggregate data will demonstrate the impact of health care reform and the cost containment strategies proposed under MinnesotaCare.

MinnesotaCare has initiated major health care system reform relying on the competitive marketplace and ISNs as the major vehicle for service delivery. Providers outside the ISN system will be reimbursed under the Regulated All-Payer Option (RAPO). One of the reasons for collecting comprehensive data on health care spending is to track the impact of major system reform and its ability to contain the growth in health care spending. The information collected through the aggregate surveys from providers and payers will be used to monitor trends in health care spending and report back to the legislature, the Commissioner, the Governor, the Health Care Commission and Minnesotans on whether the reforms have had any effect on limiting the rate of growth of health care spending.

5. The data collected will allow providers to demonstrate, to policy analysts and key decision makers, particular areas of their costs that are possibly out of their control.

There are costs directly related to the provision of health care services that will not be collected from any other source of data collection. Providers represented on the Health Care Commission recommended that data collection provide an opportunity for providers to submit data to the Department of Health to highlight some of the costs associated with the provision of care. These costs include such items as labor costs, malpractice insurance, billing and collection costs, research and education costs, and costs related to uncompensated care and charity care.

6. Aggregate data will assist health care providers in identifying trends and variances in costs.

The financial data on health care provider costs will be useful to health care providers in determining how individual health care provider clinic's or group's costs compare to average health care costs in Minnesota. The data may illustrate variances in the different aspects of health care costs. For example, a clinic may spend a certain amount on billing and collection, and the aggregate data may indicate that similar clinics spend more or less. This information would be useful to health care providers and health care administrators.

C. Emergency Rules

Emergency rules on health care provider data collection were adopted in December, 1993. Prior to the adoption of the emergency rules on data collection, the Department began communicating with affected parties and getting input on data collection procedures. In January 1993, the commissioner convened a special work group of the Data Collection Advisory Committee to work on the administrative cost portion of the data collection requirements. Department staff developed draft data collection instruments and published a notice of the new reporting requirements in the June 14, 1993, State Register.

In August through December, Department staff conducted twenty-one informational meetings and seminars in St. Paul, Minneapolis, Rochester, St. Cloud and Duluth. The people attending these seminars included health care providers, clinic representatives, certified public accountants, consultants, and health care administrators who would be affected by the new data collection requirements. Department staff presented information and answered questions and received constructive comments from the participants regarding the survey process. The draft data collection survey was revised based upon input from these meetings and a final version of the physician clinic survey was sent to all clinics registered with the Department of Human Services as entities performing health services in December of 1993.

The Department began the process of drafting emergency rules in September 1993. Public comments were received and reviewed and final emergency rules were approved and adopted on December 27, 1993. A copy of the emergency rules is included with the SONAR as an appendix. A copy of the initial data collection survey is included with the SONAR as an appendix.

D. Task Force/ Work Group

The Department convened a task force to assist with revising the emergency rules and promulgating permanent data collection rules for hospitals, providers and insurers. This task force, in turn, established work groups to specifically address the technical issues in the rules.

The health care provider data collection rule work group began meeting in March. Work group members included accountants from clinic organizations, health care providers, clinic managers, and financial officers. There were representatives from large and small health care organizations, specialty clinics, and representatives from various provider groups.

Many of the work group members had completed the initial health care provider survey for 1993. Because they had first-hand experience with the survey, they had constructive suggestions and ideas about areas for clarification and improvement. The work group began by modifying the data elements and spent considerable time revising and clarifying the definitions. Additionally, the work group discussed the issue of scope and special issues related to large and small organizations of health care providers.

A list of work group members is included with the SONAR as an appendix. Minutes from the work group meetings are included with the SONAR as an appendix.

III. Additional Requirements.

A. Small Business Considerations.

Minnesota Statutes, section 14.115, requires the Department of Health to consider the effect on small businesses when it adopts rules. The statute defines small businesses as follows:

"Subdivision 1. **Definition.** For purposes of this section, "small business" means a business entity, including farming and other agricultural operations and its affiliates, that (a) is independently owned and operated; (b) is not dominant in its field; and (c) employs fewer than 50 full-time employees or has gross annual sales of less than $4,000,000."

The rules will have a direct effect on small businesses engaged in providing health care services. According to 1992 national survey data by Medical Group Management Association, (MGMA) 60 percent of medical doctors practice in groups of 10 or fewer physicians; 22 percent in groups of 11 to 25; and 10 percent in groups of 26 to 50. This same survey measured the staffing per physician for multispecialty groups. The data indicates that an average of four and one half positions are employed per full time physician. Based upon this data, a majority of medical doctors practice in small businesses of approximately 45 or less employees. It is generally acknowledged that chiropractors and doctors also practice in small groups. Clearly, most of the businesses affected by these rules will be small businesses.

Section 14.115, subdivision 2, states in part:

"When an agency proposes a new rule, or an amendment to an existing rule, which may affect small businesses ..., the agency shall consider each of the following methods for reducing the impact of the rule on small businesses:

(a) the establishment of less stringent compliance or reporting requirements for small businesses;

(b) the establishment of less stringent schedules or deadlines for compliance or reporting requirements for small businesses;

(c) the consolidation or simplification of compliance or reporting requirements for small businesses;

(d) the establishment of performance standards for small businesses to replace design or operational standards required in the rule; and

(e) the exemption of small businesses from any or all requirements of the rule."

In addition, Section 14.115, subdivision 3 states the following:

"The agency shall incorporate into the proposed rule or amendment any of the methods specified under subdivision 2 that it finds to be feasible, unless doing so would be contrary to the statutory objectives that are the basis of the proposed rulemaking."

The Department considered the feasibility of implementing the five suggested methods in order to lessen the impact of these rules on small businesses while considering the statutory objective. The statutory objective of the rules is to collect specific financial and statistical information from health care providers. Therefore, the methods adopted to lessen the impact of the rules upon small businesses include modifying some of the specific statutory defined reporting requirements and creating a simplified version of the report for a subsection of the providers. The impact of the rules on small businesses has been reduced in the following ways:

a. Less stringent requirements.

In order to lessen the impact of the rules on the smallest businesses of the businesses that are affected, the Department has determined that a subsection of providers may complete a simplified version of the from. The proposed rules permit health care providers who are solo practitioners, or who practice in a group of three or fewer providers and have annual revenues of less than one million dollars, to complete a simplified version of the form. This simplified version does not require detailed reporting of expenses which is the portion of the survey that is the most difficult to complete. This is explained more fully in the scope section of the part-by-part statement of need and reasonableness.

Additionally, the Department modified some of the categories defined in statute in order to reflect the practice in health care provider businesses. For example, the statute requires the patient's county of residence. According to information from the health care providers, this information is not currently captured by the health care provider. Therefore, the proposed rules do not require this information.

b. Less stringent schedules.

The Department considered lessening the impact of the proposed rules by implementing less stringent schedules. The emergency rules and original law required the health care provider financial and statistical report to be submitted to the Department by February 1 with information from the previous calendar year. The original health care provider survey respondents indicated that the deadline needed to be extended in order to complete the survey with calendar year data. Therefore, the Department went to the legislature and requested a change in the reporting deadline. The deadline for reporting was extended from February 1, to April 1 in this year's MinnesotaCare Act..

Additionally, the proposed rules provide that a health care provider may request an extension to file the report. This is another method of lessening the scheduling demands imposed by the reporting requirements.

c. Consolidation or simplification of requirements.

Minnesota Statutes require health care providers to report financial and statistical data. However, as explained below in the part by part statement of need and reasonableness, it would be unduly burdensome to have individual providers submit financial and statistical data. Instead, the proposed rules provide that health care providers who practice in groups or in a clinic may jointly submit one set of data. This simplifies the reporting requirements for the health care providers, because they do not have to individually complete separate surveys. This is still consistent with the statutory objectives of collecting financial data. The health care provider data will be aggregated so that it is not necessary to receive data separately from individual providers.

Another way in which the Department consolidated or simplified requirements, is that the survey permits combining certain categories for the purpose of reporting. For example, the statute requires health care providers to report revenues from several distinct categories, "by type of payer, including but not limited to, revenue from Medicare, Medical Assistance, MinnesotaCare, nonprofit health service plan corporations, commercial insurers, integrated service networks, health maintenance organizations, and individual patients," (Minnesota Statutes, section 62J.41, subdivision, 1). The proposed rules permit health care providers to consolidate these categories and report all public programs as one category and all commercial insurance as one category. This is explained further in the part by part statement of need and reasonableness.

The proposed rules do not dictate the method (cash or accrual) for reporting financial data. In an effort to simplify the procedure for financial reporting and accommodate the different methods that a business may use for keeping financial records, the proposed rules permit health care providers to report the data on either a cash or accrual basis.

Additionally, the proposed rules do not dictate the method in which the health care provider must allocate expenses. The proposed rules permit providers to make allocations of expenses based upon their financial and record keeping level of sophistication. These issues are further explained in the part-by-part statement of need and reasonableness.

Finally, the Department simplified reporting requirements, by permitting clinics with multiple sites to submit one survey along with general information regarding each site. This lessens the burden to complete the survey, and as stated above, is still consistent with the statutory objective of collecting aggregate health care provider financial and statistical data.

d. Performance standards.

The proposed rules do not include any performance standards, so there is no consideration for using performance standards as a method of reducing the impact on small businesses.

e. Exemption.

The Department exempted certain health care providers from the health care reporting requirements. Health care provider is defined broadly in statute and includes a variety of professions involved in providing health care services. The proposed rules define health care providers as medical doctors and doctors of osteopathy, dentist and chiropractors. The Department is not collecting health care provider information from all health care providers at this time. The rationale for limiting the health care providers reporting is found under the scope section of this statement of need and reasonableness. The exemption alleviates the burden of reporting for all other health care providers such as psychologists, nurse practitioners, therapists, etc.

B. Departmental Charges Imposed By The Rules

Minnesota Statutes, section 16A.1285, does not apply because the rules do not establish or adjust charges for goods and services, licenses, or regulation.

C. Fiscal Impact

Minnesota Statutes, section 14.11, subdivision 1, does not apply because adoption of these rules will not result in additional spending by local public bodies in excess of $100,000 per year for the first two years following adoption of the rules.

D. Agricultural Land Impact

Minnesota Statutes, section 14.11, subdivision 2, does not apply because adoption of these rules will not have an impact on agricultural land.

E. Witnesses

If these rules go to a public hearing, the witnesses listed below may testify on behalf of the Department in support of the need for and reasonableness of the rules. The witnesses will be available to answer questions about the development and the content of the rules.

- Barbara Nerness, Assistant Commissioner of Health
- Mary Kennedy, Director, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Lynn Blewett, Director, Health Economics Program, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Jerry Dalnes, Senior State Planner, Robert Wood Johnson Program, Minnesota Department of Health
- Dave Orren, Rulewriter, Health Care Delivery Systems Policy Division, Minnesota Department of Health
- Dawna Tierney, Rulewriter, Minnesota Department of Health, Health Care Delivery Systems Policy Division, Minnesota Department of Health

- any other Department staff that may have expertise in the subjects within the scope of the rules

IV. Part by Part Statement of Need and Reasonableness

4651.0100 Definitions

Subpart 1. Scope

This part defines specific meanings for terms which are used to report the financial and statistical data. Most of these terms are familiar to health care providers or the clinic managers and financial staff. However, the specific interpretation of the term may vary slightly from provider to provider. Work group members stressed the fact that there should be clear definitions for reporting.

It is important to define these data elements to ensure consistent and accurate data from health care providers. Clear and complete definitions will also assist health care providers or clinic managers who are completing the survey and reporting to the department. Without comprehensive definitions, there may be confusion about where to report a specific cost or revenue.

The definitions are reasonable as they were compiled by using the definitions in the existing emergency rules and revising them based upon the recommendations of work group members who are accountants, clinic managers, and health care providers. As stated above, these are terms which are familiar to health care providers or health care administrators; they are defined to ensure consistency and to provide clarity.

Subpart 2. Bad debt.

This term is defined because it is a category in the survey. Work group members indicated that the original survey needed more definitions and more clarity. Therefore, the survey categories are defined in the proposed rules. The definition of bad debt is reasonable as it was agreed upon by the members of the work group who have financial expertise.

Subpart 3. Billing and collection costs

The term "billing and collection costs" is defined in these rules because this is a data element to be completed in the survey. Billing and collection costs are not typically tracked by traditional accounting and reporting methods. Billing and collection costs refer to a function performed in a clinic or health care provider setting and would be tracked if the clinic used functional accounting methods. If not, the individual completing the survey will have to calculate billing and collection costs by adding up costs from several traditional accounting categories and allocating costs from a variety of areas.

The work group agreed upon what functions and activities are associated with the billing and collection process. The work group requested and offered "real life" examples of what expense allocations should be included in defining billing and collection costs. Hence, the definition for billing and collection costs describes the various functions performed. The definition also indicates that billing and collection costs includes allocations of costs for space (rent) and utilities (such as electricity) and other cost allocations. The work group suggested other items to be included in the definition, such as costs for electronic claims processing systems, billing forms, postage and supplies.

Subpart 4. Charity care

This definition is necessary because charity care and bad debt costs are specifically disclosed in the survey. As stated above, work group members asked that the data elements in the survey be clearly defined. While these terms are commonly understood among health care providers, it is important to have clear definitions of what costs to be included and how to count such costs. Clear definitions will ensure uniform, reliable and accurate data. Additionally, clear definitions will assist the person completing the survey.

Subpart 5. Commissioner.

This definition is necessary because the rules repeatedly refer to the commissioner. This part clarifies that the commissioner is the commissioner of health or an appropriate employee of the Minnesota Department of Health.

Subpart 6. Discounts, Disallowed Charges, and Contractual Adjustments.

This term needs to be defined because it is a category to be reported in the survey. As stated in previous definitions, it is important to clearly define the costs included and reported under this heading.

Subpart 7. Donations, grants and subsidies.

This term needs to be defined because it is a category to be reported in the survey. As stated in previous definitions, it is important to clearly define the costs included and reported under this heading.

Subpart 8. Education revenue.

This term needs to be defined because it is a category to be reported in the survey. This category will not be applicable to a majority of health care providers. For those providers that it applies to, it is important to clearly define the costs included and reported under this heading.

Subpart 9. Education-degree program costs

For the purpose of this rule, education- degree program costs, is defined to refer to all costs for programs which would result in the conferring of a degree. This term is defined because this cost is a data element in the survey and the individual completing the survey needs clarification as to what degree program costs entail. Again, this cost is not tracked by traditional accounting methods, therefore, a definition is important.

There is not confusion as to what constitutes an educational degree program. The term is defined to assist the individual completing the survey in allocating which costs to be included this data element. As in the other cost definitions, the cost will include allocations for personnel, occupancy expenses and other miscellaneous costs defined.

Subpart 10. Education- other costs

This term is a data element in the survey and needs clarification because it has special meaning in the proposed rules. Other education costs are defined for the purpose of these rules to include costs of any other training for health care professionals and any other employees of the clinic that does not result in a degree or specialty designation.

As in the other definitions, the costs should include allocations of costs from the traditional cost areas of personnel, rent, utilities, etc. The definition clarifies that the cost must include these allocations. The work group asked for and offered examples of other education costs which are included in the definition.

Subpart 11. Encounter

Encounter needs to be defined in these rules because health care providers may have slightly differing notions of what an encounter means. The Department wants consistent measurement of encounters from year to year. In order to have valid data it is important to ensure that the same activities are consistently counted as an encounter. Some people may define encounter to mean a visit with a medical doctor, chiropractor or dentist. However, according to the definition agreed upon by the work group, an encounter is any procedure for which the health care provider has a billing code.

According to this definition, if an individual receives an allergy shot from a nurse, that is an encounter under these proposed rules because the medical doctor can bill for that procedure. An encounter cannot be defined as a face-to-face, patient to health care provider visit, because there are situations where encounters do not involve face to face meetings. Some examples of encounters which do not involve a face to face visit are laboratory studies or x-ray studies. In addition, some encounters may entail more than one face to face visit, such as prenatal services or any global surgical procedures. These services may include procedures and more than one face to face visit per encounter or billing code.

Subpart 12. Financial, accounting, and reporting costs.

The proposed rules require health care providers to report financial, accounting and reporting costs. This definition is necessary to delineate the functions and types of costs to be included in calculating this expense. As in the other cost categories, the individual completing the survey must include allocations for direct and indirect costs.

Subpart 13. Health care professional costs

This term is defined to specifically delineate that health care professionals costs include costs of independent contractors and include all forms of compensation whether that be salary or benefits or other types of compensation.

Subpart 14. Malpractice Costs.

This term is defined because there was some discussion in the work group as to how self-funded malpractice funds would be reported. The work group agreed on the proposed definition which outlines several examples of the possible types of costs to be reported as malpractice costs.

Subpart 15 MinnesotaCare Tax.

This definition gives the correct citation for the tax required under the MinnesotaCare program.

Subpart 16 Other patient care costs.

There are several types of costs which relate to patient care other than costs for health care professionals. Based upon recommendations from the group, this definition includes several examples of types of costs which are directly related to patient care which are to be reported in this category.

Subpart. 17 Patient pay.

This term needs to be defined because it is a specific category to be reported in the survey. As stated in previous definitions, it is important to clearly define the costs included and reported under this heading.

Subpart 18 Patient registration, scheduling and admissions costs.

This subpart defines a category to include all the costs related to registration, scheduling and admissions. The work group wanted to define many examples of the costs that would be allocated to this category. In addition to the receptionists and appointment schedulers, this category may include costs of medical transcriptionists and preadmission review personnel.

As in the other cost data elements, this definition includes allocations from space and occupancy costs among others.

Subpart 19 Patient/public education costs.

This definition is needed to clarify which costs are included in this category noting that there will be allocations from various traditional cost categories.

Subpart 20 Promotion and marketing costs.

This subpart defines promotion and marketing costs as distinct from patient education or wellness costs.

Subpart 21 Research costs.

This subpart defines research and gives examples of the types of costs that should be calculated in order to come up with the total research expense.

Subpart 22 Research Revenue

This term needs to be defined because it is a category to be reported in the survey. As stated in previous definitions, it is important to clearly define the costs included and reported under this heading.

Subpart 23 Utilization Review/Quality Assurance Costs

This subpart defines a cost category in the survey that will include all the costs related to utilization review and quality assurance activities. The work group requested that there be clear directions stating that these costs only need to be reported if there are designated programs or persons conducting these activities. It would be unreasonable to require the survey respondent to report the cost of these activities if they are conducted by health care professionals as an ongoing part of providing patient care. However, if there are individuals who dedicate their time or a measurable portion of their time to utilization review or quality assurance activities, then the cost of these activities can be reported.

As in the other cost data elements, this definition includes allocations from space and occupancy costs among others.

4651.0110 SCOPE

Subpart 1 Health care provider reporting.

This subpart defines which health care providers are required to complete this survey. This subpart is necessary because health care provider is defined broadly in statute, and the rules are designed to apply to a specific group of health care providers.

Minnesota Statutes, section 62J.03, subdivision 8, defines health care provider to include any person or organization, other than a nursing home, who can provide health care services for a fee. Many allied health professionals such as speech pathologists, podiatrists, and physical therapists are included in this definition. The department is not seeking financial and statistical data from all health care providers included in this definition at this time. The requirement to complete a survey must be balanced with the need and value of the survey information. The financial and statistical information is most valuable from those health care providers who account for a majority of health care expenditures. Therefore, the department is narrowing the definition of health care provider for the purpose of these rules.

Essentially, three groups of health care providers are required to submit the survey information: 1) doctors of medicine or osteopathy, 2) doctors of chiropractic, and 3) doctors of dentistry. This subset of health care providers was chosen because according to 1991 data from the U.S. Department of Commerce, medical doctors, including doctors of osteopathy, dentists and chiropractors comprise the three highest health service categories in annual receipts for noninstitutional health care, excluding receipts for the broad category of "other health practitioners." (See Estimated Annual Receipts of Health Services Businesses, 1985-1991, included with the SONAR as an appendix.)

For clarification purposes, doctors of osteopathy are listed separate from medical doctors. However, these two groups are treated synonymously. Both doctors of osteopathy and doctors of medicine are licensed to practice medicine; both are licensed and regulated by the Board of Medical Examiners; both may take the same board examinations. The distinction between the two relates to where they received their medical school training.

Subpart 2. Health Care Providers Shall Report; Date for Filing; Reporting Period.

This subpart clarifies that the three categories of providers defined in the previous subpart (doctors, dentists and chiropractors) must file a report on specific forms on or before April 1 with data from the previous year.

Although there was discussion in the work group about using a fiscal year versus a calendar year or changing the dates, the statutes clearly specify that the information is due by April 1, and that the information is from the preceding calendar year, (Minnesota Laws 1994, Article 8, Section 29)

This statutory language is repeated in the rule so that the rule is complete and contains all of the pertinent filing requirements.

Subpart 3 Clinic or Group Reporting.

This subpart provides that health care providers who practice in a clinic may jointly file one financial and statistical report. Most health care providers practice in groups organized as clinics. The original survey sent to 650 clinics in 1993 was designed to capture financial and statistical information at the clinic level. The financial and statistical data required by the proposed rules is typically accounted for by clinic staff on a clinic wide basis; it is not

generally accounted for by the individual provider. For example, net revenues or expenses are typically tracked for the clinic not for the health care provider practicing at the clinic.

It would be impractical and onerous for each health care provider in a clinic to submit separate financial and statistical data, or for clinic staff to submit financial and statistical data allocated by provider. Therefore, it is reasonable to permit health care providers organized as a group to submit one survey.

Subpart 3 Aggregate Reporting.

According to this subpart, several clinics who are operated by one corporation or organization may submit the revenue and expense survey information in the aggregate for all clinics. Some large organizations who operate several clinics do not manage each clinic independently; they might manage the clinics collectively. The financial records are kept in aggregate for the organization, not for each individual clinic site. If this is the case, it would be costly and time consuming to allocate revenues and expenses among the separate clinics. Additionally, the allocations would be somewhat arbitrary. For these reasons it is appropriate to permit aggregate reporting by organizations managing more than one clinic.

The proposed rules require the organization to include the name and address of each clinic covered by the report as well as the average number of full time equivalent employees by type of employee. This information is necessary for the Department to have basic demographic data on all clinics. It is important for the Department to monitor clinic size and location in order to track issues of access to care. Some of the work group members pointed out that there may be situations where an organization has clinic staff who rotate between clinic sites making it difficult to determine exact clinic staffing levels. In order to address that concern, the proposed rules specifically indicate that average staffing numbers are required.

Subpart 4 Small business providers.

This part permits health care providers who are solo practitioners or participants in a small clinic or group of three or fewer health care providers with net revenues less than $1 million to submit a simplified version of the financial and statistical survey. Essentially, the small business health care providers would not be required to submit detailed expense information.

The revenue and demographic portions of the survey are relatively easy to complete because the information required is typically accounted for by the health care provider or clinic. However, the data elements related to expenses are not typically tracked by health care providers. Many of these expense items need to be calculated based upon allocations of costs from various accounting categories. These allocations may be made by making estimates based upon personnel, square footage, etc.

The clinic will have to devote personnel time to calculating these allocations when filling out the survey. Typically, health care providers participating in a small clinic do not have the specialized financial staff or the sophisticated financial and record keeping ability available in

larger clinics. According to 1992 survey data from the Medical Group Management Association, (MGMA) the average medical doctor from a multispecialty group employs .96 administrative and business office staff (included with the SONAR as an appendix). Based upon this data, a clinic of three or fewer health care providers would employ two or fewer of such employees. Clinics with two or less administrative or business staff may not have the time or sophistication to calculate the expense allocations. It is reasonable to permit small clinics or health care provider groups to complete an easier version of the form.

The dollar amount of one million is included as an additional threshold. According to the same MGMA survey, the average medical doctor generates $367,000 in net revenues. Using that estimation, three health care providers practicing together would generate approximately $1.1 million dollars in net revenue. Work group members agreed that if the health care provider clinic or group is generating more than one million dollars annually, the clinic or group of health care providers is probably sophisticated enough to complete the detailed expense portion of the survey. The simple version of the form is aimed at health care providers who operate without sophisticated financial and record-keeping technology who would be unduly burdened by completing the expense allocations.

Therefore, the Department, in consultation with the work group, determined that small clinics will be required to submit their total health care expenses which would be available from any of their financial records, but they do not need to submit the detailed expense data required in the survey.

4651.0120 Reporting Requirements

This subpart details the data elements contained in the statistical and financial report to be submitted to the commissioner. The data elements are labeled in the same manner as they are labeled in the survey form which will be sent to providers.

Item A.

This item requires statistical and demographic data including the facility/organization name, county, and the federal tax identification number, or employer identification number.

The organization name is obviously necessary as a primary identifier of the data. The county is necessary because the Department tracks regional health care information by county. The Regional Coordinating Boards were established by MinnesotaCare law to monitor health care needs and issues based upon geographic areas. The health care provider data will be useful for geographic analysis only if the data can be identified by county. With county specific statistical and financial information, the Regional Coordinating Boards will be able to monitor regional and, importantly, rural health care issues.

The requirement for the tax identification number may be necessary in the development of joint data collection efforts with the Department of Revenue. Minnesota law specifically directs the commissioner to establish linkages with the Department of Revenue if that is the most efficient method of collecting revenue data, (Minnesota Statutes, section 62J.41,

subdivision 2). Currently, the Department of Revenue collects health care provider revenue data in order to assess the two percent MinnesotaCare tax, and their basis for identifying health care providers is the tax identification number. In the future, when the Department of Health has established a database of statistical and demographic information about health care providers, the Department of Health may be able to collect the health care providers' revenue data from the Department of Revenue. This will eliminate a double reporting requirement for the health care provider; health care providers only need to submit revenue data to one department assuming the maintenance of the two percent provider tax. The Department of Health will be able to access health care provider revenue data from the Department of Revenue if there is a database of providers that contains a taxpayer identification numbers as part of the identifying information about health care providers.

Item B

This item requires basic identifying information about the health care provider: the name and specialty field of the health care provider and the UPIN or Minnesota License number. This item is necessary first for establishing a database with uniform identifying information about health care providers, and, second, to enforce the data reporting statutory requirements.

Clearly, health care provider financial and statistical data collection must begin with basic identifying information about the health care providers. The name is the primary identifier. However, because names are not always unique to individuals, a secondary form of identification is necessary. In addition to the name of the health care provider, the proposed rules require the provider's unique provider identification number (UPIN).

The Health Care Financing Administration (HCFA) assigns UPIN's to health care providers who receive Medicare reimbursement. These numbers are published, public data because they are used routinely in billing. The UPIN numbering system began with medical doctors and now is expanding to include all health care providers. Health care providers who do not have UPINs, will use their Minnesota license number until assigned a UPIN. Increasingly, UPIN's are becoming the standard identifier for providers. The 1994 MinnesotaCare Act specifies that after January 1, 1996, all group purchasers (define) in Minnesota shall use the UPIN as the uniform identifier for health care providers for the "purpose of submitting and receiving claims, and in conjunction with other data collection and reporting functions." (Minnesota Laws 1994, article 9, section 5, subdivision 2.)

In order to enforce the data reporting requirements of the law, the commissioner will have to check the names of health care providers submitted in the survey against the complete list of licensed providers. In practice, clinics or health care provider groups will submit the survey. The identifying information about the clinic or group does not include identifying information about the health care provider. Identifying information about the health care provider is essential for monitoring health care provider compliance with health care provider data reporting requirements.

Finally, the provider's specialty field is required so that the Department can monitor issues related to access. Minnesota Statutes, section 62J.41, subdivision 1, permits the

commissioner to require any data for the purpose of monitoring costs and quality. A basic issue in relation to quality of care is access or availability of care. For example, in certain geographic areas there are concerns about specific provider availability. It is reasonable to request basic provider specialty information to enable the commissioner to monitor these important access to care issues.

Item C

This item requires the total number of full-time equivalent employees for the health care provider by type of employee. This information is specifically required by Minnesota Statutes, section 62J.41, subdivision 1. It is repeated here in rule so that the rule contains a complete list of the survey requirements. It would be cumbersome to have to look at the statute and the rule to determine what is required in the report. Therefore, it is reasonable and necessary to repeat the statutory provision in the rule.

Item D.

Item D is specifically required by statute. Minnesota Statutes, section 62J.41, subdivision 1 requires health care providers to provide information on total number of patients served by state of residence and county. The proposed rules do not require patient information by county at this time. Currently, health care providers do not ask patients for their county of residence as part of the patient registration process. If the Department required county information, clinics would have to change their patient registration forms and processes. Therefore, it is not reasonable to request this information at this time.

Item E.

This item is simply an indication of the method of accounting used to complete the survey. This eliminates confusion on the part of the person completing the survey, because the respondent may choose to complete the survey based on their own method of financial record-keeping. Accountants or financial managers typically track revenues and expenses using accrual, cash or modified cash methods. In practice, any of these methods will be valid for the purposes of completing the survey.

Item F.

The next requirement is signature and telephone number of the person completing the survey and certification that the contents of the report are true. This item is necessary first to designate one person who is responsible for the survey data. This person will serve as a contact person if there are any follow-up questions regarding the survey. This requirement also is needed to ensure the accuracy and reliability of the data by holding someone accountable to the accuracy of the data.

Item G.

This item is necessary because it is a specific requirement in Minnesota Statutes, section 62J.41, subdivision 1.

The statute specifies that patient receipts be itemized by type of payer. This information will inform health care policy planners of any shifts in the payer mix over time. Policy analysts will watch to see what reliance there is on public programs and if that changes over time. The Department is also interested in monitoring any increases or decreases in patient responsibility in the form of consumer out-of-pocket spending.

The proposed rule follows the statutory requirements except for a few minor changes. First, the proposed rule combines Medical assistance, General Assistance Medical Care (GAMC) and Minnesota Care in one category. Health care providers receive a remittance advice from the Minnesota Department of Human Services which includes payments for these three public funded programs. It would be cumbersome to itemize the payments for these programs line by line to allocate the revenue into three separate categories. Therefore, it is reasonable to permit the health care provider to report the total revenue from these state-administered public programs.

Additionally, the proposed rule requires a disclosure of patient pay revenues which includes self-filed insurance and out-of-pocket spending. Although the statute requires data on revenues from out-of-pocket payments by patients, it is not feasible at this time to capture patient out-of-pocket spending as an element separate from total patient pay revenues for the following reasons.

Money is collected from patients rather than payers under the following scenarios: 1) the insurance plan does not cover the procedure, 2) the patient is paying a copayment or deductible, 3) the person is uninsured, or 4) the person intends to seek reimbursement from the insurance company for the payment to the provider. Any of these scenarios may be the case when a patient pays for a service personally. The clinic keeps track of money that comes from the patient, however, the clinic cannot easily identify nor does it investigate why the patient is paying in order to separate patient out-of-pocket expenses from revenue from payers. Because the clinic is only able to determine which revenues come from patients, not why the revenues are coming from the patient, it is reasonable to rename this category.

The are two other minor changes from the statute in the proposed rules. The proposed rules combine commercial insurers and nonprofit health plans because clinic or health care provider groups typically account for these receipts together. Further, both commercial insurers and nonprofit health service plans (Blue Cross Blue Shield and Delta Dental) offer insurance type products. Finally, the proposed rules do not require a category for integrated service networks which is required in statute, because integrated service networks are not fully implemented as of yet.

Item H.

The proposed rules require a statement of other operating revenue itemized into four categories under item H. This item is necessary because it is specifically required in Minnesota Statutes, section 62J.41, subdivision 1. The statutory requirement is repeated in rule so that the rule contains a complete list of the reporting requirements. As stated previously, it would be cumbersome to have to look at the statute and the rule to determine what is required in the report. Therefore, it is reasonable and necessary to repeat the statutory provision in the rule.

As a practical matter, item H also includes a category for "other" revenues that are not captured in the categories in G and H. This is necessary to capture revenues received from such items as cafeteria, vending commissions, legal reviews, parking fees, etc.

Item I.

This is simply an instruction to sum to the total revenues.

Item J.

Item J requires the health care provider to report any charity care and bad debt. This item is necessary to get a complete and accurate picture of the health care provider's health care costs. Minnesota Statutes, section 62J.41, subdivision 1 states that the commissioner may collect any other data "for the purposes of...monitoring costs." Charity care and bad debt are a portion of the providers costs. One of the original reasons to collect data from providers was to capture this information in order to get a more complete picture of health care spending in the State. Currently there is anecdotal information about the amount of free care given by providers in Minnesota. Policy analysts note that there is "little research conducted on uncompensated care provided by physicians." (Dunham, et al, JAMA 1991). Research in Wisconsin estimates that 4.6 percent on total billings are for charity care and bad debt, (Dunham, 1991). An earlier study in San Francisco estimates charity care and bad debt at 7 percent of total billings. (Hogeland, 1988).

With data, the Department can quantify this cost. The Department will assess whether or not charity care costs fall disproportionately on health care providers. In addition, it will be important to monitor this cost over time to see if health care reforms reduce the aggregate cost of charity care and bad debt.

Item K.

This item is an optional statement of disallowed charges. When the original survey was sent out in 1993, Department staff met with 1,200 clinic managers, directors and administrators to address survey issues. Approximately 80 percent of these people requested the opportunity to report disallowed charges. As stated in the definitions, disallowed charges are the difference in the amount billed by the health care provider for a service and the amount that the provider is not allowed to collect because of contractual agreements with payers.

If the providers are interested in reporting this item, the Department is willing to aggregate this item as part of the data collection. As stated earlier, the data is meant to be useful to health care providers as well as researchers.

Item L.

This item requires a detailed statement of expenses for the health care provider. The purpose of the expense portion of the survey is to identify and measure key functional categories of health care provider costs. The survey required by the emergency rules, which was submitted by clinics in 1994, contained a detailed breakdown of costs incurred in 1993. In the 1994 survey of 1993 costs, direct service costs or patient care costs were reported separate from administrative cost categories.

The 1992 and 1993 MinnesotaCare Acts required the Commissioner of Health to study administrative costs in the health care system in the interest of identifying and recommending cost savings and efficiencies related to administrative costs. Minnesota Laws 1993, chapter 345, article 3, section 17, titled "Study Of Administrative Costs" states:

> "The data analysis unit shall study costs and requirements incurred by health carriers, group purchasers, and health care providers that are related to the collection and submission of information to the state and federal government, insurers, and other third parties. The data analysis unit shall also evaluate and make recommendations related to cost-savings and efficiencies that may be achieved through streamlining and consolidating health care administrative, payment, and data collection systems. The unit shall recommend to the commissioner of health and the Minnesota health care commission by January 1, 1994, any reforms that may produce cost-savings and efficiencies without compromising the purposes for which the information is collected."

Additionally, Minnesota Statutes, section 62J.41, subdivision 1, clause (11), requires providers to submit "any other data required by the commissioner . . . for the purposes of . . . monitoring actual spending, and monitoring costs and quality."

There has been continuing and intense interest in administrative costs generally by persons interested in health care reform and specifically by the Legislature. Because of this, the Department decided to include administrative cost data as part of its annual aggregate data collection effort. The starting point for the survey under the permanent rules was the survey under the emergency rules. To understand the development of and rationale for the permanent rules survey, it would be instructive to look at the development of and rationale for the emergency rules survey.

In developing the original survey and emergency rules, the Department worked with a work group formed from the Data Collection Advisory Committee. In their preliminary research, the group and the Department found that estimates of administrative costs vary based on operational definitions, data sources, measurement techniques, and theoretical assumptions.

Cost accounting is a complex exercise, the principles of which vary among the various components of the health care system. It should also be noted that the definition, identification, measurement and analysis of administrative costs is likely to become even more difficult with a further integration of the various components of the health care delivery system. Managed care and capitation further challenge traditional accounting procedures and cost-finding. Thus the concept of administrative costs will become more ambiguous, less precise, increasingly controversial and, consequently, of little analytic value, unless a consistent conceptual framework and uniform accounting procedures are applied.

Despite the inherent difficulties with the issue of administrative costs, the Department felt that measuring these costs as well as costs directly related to patient care was important to provide a total picture of health care spending. It will be important to collect and maintain data to chart the trend in all sectors of health care spending in order to make informed policy decisions and to adequately assess the impact of health care reform legislation. However, in order to meaningfully and accurately measure these costs, the Department needed to develop a framework to consistently identify these costs. For the emergency rules survey, the Department, in conjunction with the Data Collection Advisory Committee, looked to Kenneth Thorpe's framework for identifying administrative costs as a model.

Thorpe's model for categorizing and analyzing administrative costs was presented in the Summer 1992 volume of Health Affairs. Thorpe begins by explaining that administrative costs should be identified as "inputs" into the "function" of health care providers and payers. He notes that "investments in administrative spending produce or support several outputs, including patient care, clinical and health services research, and education," (Thorpe, 1992). Importantly, Thorpe's conceptualization of administrative costs includes a framework which may help distinguish which costs "are amenable to change and those where reductions could increase total (health care) spending." There are administrative functions that, if eliminated would increase health care spending. For example, a study of industry data reveals that every dollar spent on utilization management reduces claim costs from one to nine dollars, (Sheils, et al., 1992). In addition, Thorpe's research and article clearly acknowledge the difficulty in comparing administrative costs across payers and providers.

In his paper, Thorpe groups administrative costs by function into four categories: 1) transaction-related, 2) benefits management, 3) selling and marketing, and 4) regulatory/compliance. Within these functions are various administrative activities or inputs. The administrative costs work group of the DCAC began with the Thorpe system for categorizing administrative costs. The work group expanded some of the expense categories described by Thorpe. These were the categories used in the 1993 survey of 1994 data.

After the clinics completed the 1994 survey of 1993 data it was clear that one of the difficulties in using the Thorpe model of administrative cost functions, is that the cost data required for the survey categories are different from the cost data contained in the typical health care provider financial statement or easily accessible within the financial statement. Thorpe's methodology for determining functional costs does not follow traditional general ledger accounting. A typical financial statement does not reflect the cost of the functions defined by Thorpe and used in the original survey. Many clinic managers expressed

problems in completing the survey because they did not know what expenses to include in the categories. The original survey and emergency rules did not adequately define what costs to include and how to calculate these costs from typical clinic financial data.

In order to transform standard financial data into the Thorpe functional categories, the survey respondent needed to allocate costs from traditional categories from the chart of accounts. For example, the Thorpe-defined transaction-related function includes billing and collection costs. Billing and collection costs are not a unique item in a typical chart of accounts. However, items such as postage, service bureau fees, wages, and rent, which contribute to the process of billing and collection as well as many other functions are included within the chart of accounts. In order to determine the billing and collection functional cost, the survey respondent had to allocate and sum up the costs of the various inputs that comprise billing and collection costs.

It is necessary for the proposed rules survey instrument to include a statement which instructs the survey respondent in the method for making expense allocations. The proposed rules do not prescribe one precise method for making expense allocations. It was determined, with the work group's recommendation, that it was important to have a flexible approach for making allocations. The instructions provide examples of methods for making allocations. Based upon these examples, the expense allocations will be made in a generally similar manner. Because of the variety of health care provider settings and the various administrative and organizational schemes, one rigid approach for allocating expenses would be unworkable.

Work group members suggested several methods that would be appropriate for allocating costs that consider the nature of the health care providers' business and the sophistication and capabilities of their financial and record-keeping functions. For example, one health care provider practicing in a small group may be able to make an independent judgement about the percentage of personnel time spent on a particular function. Another provider in a large group setting which uses computerized scheduling may have that information available on the computer. Either method is acceptable. When the original survey was sent to clinics, accountants and consultants developed various spreadsheets with examples of methods for making functional allocations.

The work group members who completed the 1994 survey of 1993 data also voiced their concerns and problems with the labeling of particular functional cost categories in the original survey. Work group members said that some of the categories did not reflect the nature of their health care provider business. They indicated that many of the classifications or labels were unnatural. In addition, they found it very difficult to accurately separate patient care from "administrative cost" activities. Finally, there were concerns about labeling costs as "administrative" which may be potentially interpreted as "unnecessary paper shuffling" or potentially perceived as "bad costs" by some policy makers.

Clearly the intent of the survey is to isolate and collect data on provider costs in order to first measure the costs of various functions and then monitor the change in those expenditures over time. The work group determined, therefore, it was not necessary to label the

functional categories as either patient care costs or administrative costs. In fact, the work group felt it was important to not label any group of categories as "administrative costs" because if the line could not adequately be drawn between administrative and patient care costs, the data could potentially be misleading or be misused. To prevent this, it is important to clearly define each category so that the people completing the survey understand how to compile the data and so that the people using the data understand what is included in the categories.

The work group recommended combining some of the categories, expanding some of the categories, and deleting some of the categories in an effort to present a more rational and understandable means of reporting health care provider expenses. In addition, each definition was extensively rewritten in language familiar to those who will complete the survey. The original survey expense categories and the work group's proposed expense categories are as follows:

Previous categories	Proposed categories
Salaries/wages health care professionals	Health care professional costs
Employee benefits	Other patient care
Purchased services/other health care costs	Malpractice costs
Malpractice insurance	Billing and collection costs
Billing and collections	Patient regis./scheduling/admission
Admissions/patient regis	Financial, accounting, reporting
Govt/internal reporting requirements	Research costs
Utilization review/regulatory compliance	Education- degree program
Professional fees/association fees	Patient/public health education
Research	Education- other
Education	Promotion and marketing
General administration	MinnesotaCare tax
Selling/marketing	Other
Other	Est. cost of Govt reporting requir.

"Health care professional costs" and "other patient care costs" were proposed as categories that would include all costs (benefits etc.) for employees directly providing health care services. These categories are the largest expense categories for the health care provider and categories that the Department wants to monitor over time to be aware of changes.

Malpractice costs have risen dramatically over the years. This category is often the largest expense for the health care provider after labor costs. According to a survey of office-based physicians published in Medical Economics in 1988, malpractice costs rose 157 percent from 1982 to 1987. This same survey indicates that malpractice costs consume over four percent of office-based physician costs. Certainly, malpractice costs are important to quantify and monitor as an area where appropriate policy reforms may slow the increase in this cost. According to information from work group members, the category for malpractice costs is relatively easy to calculate, and the information will be useful in the aggregate.

The categories "Billing and collection costs" and "Patient registration, scheduling and admissions costs" are functional cost categories. These categories include all costs associated with performing billing and collection activities and all costs associated with registering and scheduling patients. These categories were identified by work group members as key functions for health care providers which will provide meaningful information to track over time. In order to determine the costs for these categories, the survey respondent will have to make allocations from personnel, rent, supplies, and so on, as explained previously.

The "Financial , accounting, and reporting costs" category will include all fiscal service costs as explained in the definitions. The work group agreed that this category will provide meaningful information and is workable to track because the category was well defined in the proposed rule and in the survey.

The category for utilization review and quality assurance costs will include all costs related to utilization management and quality assurance activities. As stated above, researchers have estimated that every dollar spent on utilization management yields a reduction in overall health care costs. It will be valuable to track the amount of resources devoted to utilization review and quality assurance activities over time. It is important to note that the Department's intent in including this category is to capture information only where there are dedicated units, and not to require allocation of a person's time if that person performs this function in conjunction with other duties.

The categories for research and education costs were included in the Department's expanded framework of functional cost categories. Minnesota Statutes, section 62J.41, subdivision 1, specifically requires data on health care providers' research and education revenues. It follows that the Department should collect data on these costs. Education costs were broken into three separate categories because of the different purposes and expected outcomes for each of the three categories.

Promotion and marketing costs are included to report selling and marketing functions. While most work group members indicated that these costs would be very small at present, as ISN's come into existence, there will likely be competition for enrollees or patients. This competition might lead to increases in promotion and marketing costs over time.

The work group specifically asked to include a category to report the MinnesotaCare tax. The reason for reporting this tax is to indicate the providers' burden for funding the health care access fund.

The final category is other costs not include in the above categories. This category is necessary because the categories listed above are not all inclusive. There are other health care provider expenses that are not reflected in the other categories which would include general administration costs such as duplicating and personnel management costs.

Item M.

This item in the proposed rules asks the survey respondent to report the amount of time spent to complete the survey. This item is necessary because the Department needs to monitor the burden of its reporting requirements on providers. Minnesota Statutes, section 62J.30 subdivision 6, specifically directs the data analysis program to collect data "in the most cost-effective manner, which does not unduly burden them." Clearly any reporting requirements will impose a cost on providers, this item will permit the Department to monitor the costs in terms of time.

Item N.

This item requires the survey respondent to estimate the cost to comply with all government reporting requirements. In addition to Department of Health reporting requirements, health care providers are subject to a variety of reporting requirements depending on their participation in any number of federal, state, and local government programs. Clearly, the cost of complying with these reporting requirements adds to total health care costs. The Department is interested in monitoring these reporting costs in order to measure the amount of these costs and determine whether or not these costs are increasing or decreasing.

Originally, the initial survey sent out under the emergency rules included the costs of complying with government reporting requirements as a category under health care expenses. However, the work group members explained that it was extremely difficult to determine the costs of government reporting requirements distinct from other financial reporting requirements without conducting time studies, because they do not typically track that type of activity. Work group members said it would be possible for them to estimate the cost of complying with government reporting requirements, therefore the proposed rules include this item.

Item O.

This item asks the respondent to report whether or not outside help was necessary for completing the survey. As stated above, this is another attempt to monitor the burden of the reporting requirements.

4651.0130 Filing of Reports; Extensions.

This part permits a health care provider to obtain an extension to file the report. It is reasonable to provide an extension for health care providers who would have difficulty complying with the deadline. According to respondents from the original survey, health care providers may experience unusual circumstances, or other difficulties which would require additional time to complete the survey. This part is necessary to provide health care providers with a procedure for requesting and receiving additional time to complete the survey.

4651.0140 Review of Reports

This part is necessary to set up a schedule of review of the report data for the Department and the health care providers. Both the Department and the survey respondents will benefit from established time frames for review, amending, and correcting data in the reports.

Subpart 1. Completeness

This part gives the commissioner 60 days to review the report for completeness. In practice, most of the health care provider reports will be submitted to the Department on or near the filing deadline. The Department will need sufficient time to review the reports for acceptability and adequacy of data. Based on the experience with the original survey, the Department determined 60 days is necessary to review the reports for completeness.

Subpart 2. Incomplete Report

This subpart is necessary to establish a time frame for the health care provider to amend an incomplete report and resubmit the report to the Department. The emergency rules required resubmission of the report in 14 days. Work group members indicated that 30 days was necessary to amend the report and resubmit the data.

Subpart 3. Amending Reports.

This subpart is necessary to provide a procedure for health care providers to amend the information submitted in the report to the Department. Undoubtedly, there will be situations where a health care provider has found error in its submitted report. This subpart provides a manner for correcting such errors.

Subpart 4. Error in Reports.

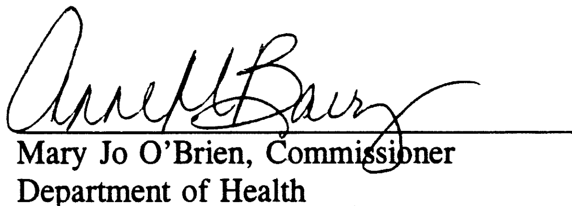
This subpart provides that the commissioner may require the health care provider to amend the report if the commissioner discovers an error in the statements or calculations. This subpart is necessary to establish a procedure for amending data if the commissioner discovers the error in the data.

V. Conclusion.

Based on the foregoing, the Department's proposed rules are both necessary and reasonable.

Aug 2, 1994

Date



Mary Jo O'Brien, Commissioner
Department of Health

Appendix

Items in the Appendix are included as part of the official rulemaking record. Copies of Appendix items are available upon request from Jerry Dalnes, Minnesota Department of Health, Health Care Delivery Systems Policy Division, P.O. Box 64975, 171 East Seventh Place, Suite 400, St. Paul, Minnesota 55164-0975, 612/282-6312. TDD users may call the Minnesota Department of Health at 612/623-5522.

A. Table on National Health Expenditures, By Source of Funds And Type of Expenditure, Billions of Dollars, Calendar Year 1991.

B. Emergency rules chapter 4651, effective from 12/14/93 through 12/9/94.

C. 1994 data collection survey of 1993 data under emergency rules chapter 4651.

D. List of work group members.

E. Minutes of work group meetings. Note that minutes are included for the purpose of documenting the work group's input, and do not necessarily represent the Department's position.

F. Estimated Annual Receipts of Health Services Businesses, 1985-1991.

G. 1992 survey data from the Medical Group Management Association.

Appendix A

Exhibit 6
National Health Expenditures, By Source Of Funds And Type Of Expenditure, Billions Of Dollars, Calendar Year 1991

		Private					Government		
			Consumer						
Type of expenditure	Total	All private	Total	Out of pocket	Private insurance	Other[a]	Total	Federal	State/local
National health expenditures	$751.8	$421.8	$388.6	$144.3	$244.4	$33.2	$330.0	$222.9	$107.1
Health services and supplies	728.6	412.7	388.6	144.3	244.4	24.1	315.9	212.0	103.9
Personal health care	660.2	377.0	353.5	144.3	209.3	23.4	283.3	204.1	79.1
Hospital care	288.6	126.0	111.4	9.9	101.5	14.7	162.6	119.1	43.5
Physician services	142.0	92.5	92.5	25.7	66.8	0.1	49.4	39.0	10.4
Dental services	37.1	36.0	36.0	19.9	16.1	–	1.1	0.6	0.5
Other professional services	35.8	27.5	23.0	9.7	13.3	4.4	8.4	6.4	2.0
Home health care	9.8	2.7	2.0	1.2	0.7	0.7	7.1	5.7	1.3
Drugs and other medical nondurables	60.7	53.3	53.3	44.3	9.0	–	7.3	3.6	3.7
Vision products and other medical durables	12.4	8.8	8.8	7.7	1.2	–	3.5	3.1	0.4
Nursing home care	59.9	27.6	26.5	25.8	0.6	1.1	32.3	19.5	12.8
Other personal health care	14.0	2.4	–	–	–	2.4	11.6	7.0	4.6
Program administration and net cost of private health insurance	43.9	35.7	35.1	–	35.1	0.6	8.1	5.2	3.0
Government public health activities	24.5	–	–	–	–	–	24.5	2.7	21.8
Research and construction	23.1	9.1	–	–	–	9.1	14.0	10.9	3.2
Research[b]	12.6	0.9	–	–	–	0.9	11.7	10.2	1.5
Construction	10.6	8.2	–	–	–	8.2	2.4	0.7	1.6

Source: Health Care Financing Administration, Office of the Actuary.
[a] Includes funding through philanthropy and other nonpatient revenues, business spending for industrial in-plant health services, and privately financed construction.
[b] Research and development expenditures of drug companies and other manufacturers and providers of medical equipment and supplies are excluded from "research" expenditures but are included in the expenditure class in which the product falls.

Understanding Rising Health Costs

Health spending has been growing faster than other sectors of the economy. To set policy that will effectively control health costs, it is essential to understand the role that price increases as well as changes in quantity play in increasing health spending.

Factors causing growth in health spending. Expenditures are the product of the quantity (including intensity) of goods or services purchased and the price paid for goods or services. Over the past three decades the role of price and quantity in personal health care expenditures has changed. Factors affecting price growth are economywide and medical price inflation in excess of overall inflation; factors affecting quantity growth are population changes and increases in use and intensity of services per person.

Personal health care spending grew at an average annual rate of 10.6

Appendix B

CHAPTER 4651
DEPARTMENT OF HEALTH
HEALTH SYSTEMS DEVELOPMENT DIVISION
DATA REPORTING AND COLLECTIONS; AGGREGATE DATA, HEALTH CARE PROVIDERS

4651.0100 [Emergency] DEFINITIONS.

Subpart 1. **Scope.** For the purposes of parts 4651.0100 to 4651.0170 [Emergency], the following terms have the meanings given to them.

Subp. 2. **Accrual method.** "Accrual method" has the meaning given in part 8130.1800, subpart 3.

Subp. 3. **Admitting expenses.** "Admitting expenses" means all direct costs incurred in the filling of admission forms, both for scheduled and nonscheduled admissions, scheduling of admission times, receiving and transferring of patients to final destination, and arrangement of all other admission details. Direct costs include wages and benefits, supplies, purchased services, and any other resource used in accomplishing these activities.

Subp. 4. **Average fee.** "Average fee" is determined by adding the provider's price for each service in the provider's fee schedule across the number of months that the price was in effect in a 12-month period, divided by 12.

Subp. 5. **Bad debt.** "Bad debt" has the meaning given in part 4650.0102, subpart 6.

Subp. 6. **Billing and data processing expenses.** "Billing and data processing expenses" means all direct costs incurred in the processing of charges to patients' accounts, preparing and submitting claim forms, cashiering, credit and collection functions, and maintaining and operating the data processing system of the organization. Direct costs include wages and benefits, professional fees, supplies, purchased services, and any other resource used in accomplishing these activities. Also included are all wages and benefits and other direct costs incurred in the administration of the coordination of benefits procedures that exist for group contracts or other health plan contracts. Coordination of benefits refers to the set of provisions establishing the general order in which benefits are determined when a person is covered by more than one plan.

Subp. 7. **Cash method.** "Cash method" has the meaning given in part 8130.1800, subpart 2.

Subp. 8. **Charity allowances.** "Charity allowances" has the meaning given in part 4650.0102, subpart 9.

Subp. 9. **Clinic.** "Clinic" means an entity enrolled in the medical assistance program to provide rural health clinic services, public health clinic services, community health clinic services, or any other entity that provides the health services of two or more physicians or dentists.

Subp. 10. **Commissioner.** "Commissioner" means the commissioner of the Department of Health.

Subp. 11. **Department.** "Department" means the Minnesota Department of Health.

Subp. 12. **Discount or price differentials.** "Discount or price differentials" has the meaning given in part 4650.0102, subpart 12.

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Subp. 13. **Donations.** "Donations" means the value of goods or services, including in-kind donations, given to a health care provider by an individual or organization not in fulfillment of a legal obligation, with or without specific purpose, and that will offset overall costs incurred by the health care provider in its operation.

Subp. 14. **Educational program expenses.** "Educational program expenses" has the meaning given in part 4650.0102, subpart 13.

Subp. 15. **Encounter.** "Encounter" means any visit or procedure provided as a service to a patient and for which the provider can bill the patient or third party payer, including any procedure code in the Current Procedure Terminology (revision 4), or any other billing code system.

Subp. 16. **Fees expenses.** "Fees expenses" means all costs associated with the organization's new or renewal certification with state or federal regulatory agencies, and examination costs related to regulation including any fines levied against the organization.

Subp. 17. **Fee schedule.** "Fee schedule" means a health care provider's list of prices charged to a patient or third party payer for each health care service provided, including all visits and services for which a price has been established.

Subp. 18. **Full-time equivalent.** "Full-time equivalent" means an employee or any combination of employees that are reimbursed by the health care provider for 2,080 hours of employment per year.

Subp. 19. **General administration expenses.** "General administration expenses" means all costs associated with the overall management and administration of the organization, such as costs of governing boards, executive wages and benefits including stock options, legal staff functions that primarily concern the overall management and operation of the organization and excluding legal staff already allocated to other functions, auxiliary and other volunteer groups, public relations not included in selling and promotion or government relations, purchasing, communications, printing and duplicating, receiving and storing, and personnel management. It also includes all costs related to fiscal services, such as general accounting, budgeting and costs, payroll accounting, accounts payable, plant and equipment, and inventory accounting.

Subp. 20. **Government contractual allowances.** "Government contractual allowances" has the meaning given in part 4650.0102, subpart 20.

Subp. 21. **Government relations expenses.** "Government relations expenses" means all wages and benefits, donations, and financial and other support for the purpose of lobbying and influencing policymakers and legislators, including membership in trade organizations and all expenses associated with public policy development, such as response to rulemaking and interaction with government agency personnel. Membership in trade association projects that are directly related to research and education are excluded.

Subp. 22. **Government subsidies.** "Government subsidies" means an appropriation or allocation of money made by government to a health care provider to offset the costs incurred by the health care provider for the provision of direct patient care or other operations in which the governmental entity desires to participate, or that is considered a proper subject for government aid because the purpose is likely to be of benefit to the public.

Subp. 23. **Grants.** "Grants" means an award of money pursuant to a written agreement signed by the eligible applicant and by the official representative of the organization

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awarding the grant, setting forth the amount of funds, the time period within which the funds are to be expended, the purpose for which the funds may be used, and other contractual conditions.

Subp. 24. **Health care provider.** "Health care provider" has the meaning given in Minnesota Statutes, section 62J.03, subdivision 8.

Subp. 25. **Health maintenance organization.** "Health maintenance organization" has the meaning given in Minnesota Statutes, section 62D.02, subdivision 4.

Subp. 26. **Insurance company.** "Insurance company" means an organization licensed under Minnesota Statutes, chapter 60A, to offer, sell, or issue a policy of accident and sickness insurance as defined in Minnesota Statutes, section 62A.01.

Subp. 27. **Medical assistance.** "Medical assistance" means the program established under title XIX of the Social Security Act, United States Code, title 42, section 1396, and Minnesota Statutes, chapter 256B. Medical assistance includes general assistance medical care or GAMC, as defined in part 9505.0500, subpart 12, unless otherwise specified.

Subp. 28. **Medicare.** "Medicare" means the health insurance program for the aged and disabled under title XVIII of the Social Security Act, United States Code, title 42, section 1395.

Subp. 29. **MinnesotaCare.** "MinnesotaCare" means the program established under Minnesota Statutes, section 256.9352, subdivision 1.

Subp. 30. **Minnesota resident.** "Minnesota resident" means a person who resides within the borders of the state at the time of contact with the health provider. In the case of minors, residency shall be determined as that of the parent or legal guardian.

Subp. 31. **Net patient receipts.** "Net patient receipts" means total charges for patient care services less discounts and allowances. If using a cash-base accounting system, it only includes actual receipts for the reporting period.

Subp. 32. **Out-of-pocket expenses.** "Out-of-pocket expenses" means the receipts due from the patient to the health care provider for the provision of health services that are not paid or payable if claim were made under any plan of health coverage, Medicare, or other government program, but are the personal liability of the patient. This includes receipts due from patients for deductibles, copayments, and services not covered by insurance.

Subp. 33. **Patient.** "Patient" has the meaning given in Minnesota Statutes, section 144.335, subdivision 1.

Subp. 34. **Quality assurance expenses.** "Quality assurance expenses" means all direct costs associated with any activity or program established for the purpose of quality of care evaluation and utilization management. Direct costs include wages and benefits for personnel time devoted to, or in direct support of such activities as quality assurance, development of practice protocols, utilization review, peer review, provider credentialing, and all other medical care evaluation activities, including the communication of information regarding these activities. Direct costs also include all professional fees, supplies, purchased services, and any other resource used in accomplishing these activities, and the implementation of programs of wellness education, patient education, or health promotion, including the cost of professional staff and materials, participant's notification of services, and mail costs.

Subp. 35. **Regulatory and compliance reporting expenses.** "Regulatory and compliance reporting expenses" means all direct costs associated with, or directly incurred in

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the preparation and filing of financial, statistical, or other utilization, satisfaction, or quality reports, or summary plan descriptions that are required by federal, state, and local agencies or other third parties. Direct costs include wages and benefits for personnel time, professional fees, supplies, purchased services, and the cost of any other resource used to fulfill these requirements.

Subp. 36. **Research program expenses.** "Research program expenses" has the meaning given in part 4650.0102, subpart 35.

Subp. 37. **Revenue or income.** "Revenue" or "income" has the meaning given in part 4650.0102, subpart 36.

Subp. 38. **Revenue per encounter.** "Revenue per encounter" means the ratio of net patient receipts less allowable deductions to the total number of encounters.

Subp. 39. **Revenue per patient per year.** "Revenue per patient per year" means the ratio of net patient receipts less allowable deductions to the total number of patients serviced by the provider during a given year.

Subp. 40. **Selling and promotion expenses.** "Selling and promotion expenses" means all direct costs related to marketing activities such as advertising, printing, marketing representative wages and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity. All costs associated with health promotion, wellness education, and patient education programs are excluded. Costs associated with health promotion and education should be distinguished from costs incurred while educating enrollees and patients about the services available from the organization.

Subp. 41. **Service plan corporation.** "Service plan corporation" has the meaning given in Minnesota Statutes, section 62C.02, subdivision 6.

Subp. 42. **Taxes and assessments expenses.** "Taxes and assessments expenses" means the direct payments made to government agencies including the MinnesotaCare provider tax under Minnesota Statutes, section 295.52, contributions to the Minnesota comprehensive health association under Minnesota Statutes, section 62E.10, the provider surcharge under Minnesota Statutes, section 256.9657, assessments by the health coverage reinsurance association, assessments by the Minnesota life and health insurance guaranty association, and any new assessments imposed by federal or state law. This category does not include fees or fines paid to government agencies.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0110 [Emergency] SCOPE.

All health care providers as defined under part 4651.0100 [Emergency], subpart 24, that were registered with the Department of Human Services as physician clinics as of May 12, 1993, as defined in part 4651.0100 [Emergency], subpart 9, and that are not subject to the reporting requirements under Minnesota Statutes, sections 144.695 to 144.703, are subject to the reporting requirements established by part 4651.0120 [Emergency].

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

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4651.0120 [Emergency] REPORTING REQUIREMENTS.

Subpart 1. **Basic contents.** A health care provider must file with the commissioner at least annually a financial and statistical report by the dates specified in part 4651.0140 [Emergency], subpart 1. The report must include statistical and financial information for the reporting period specified in part 4651.0140 [Emergency].

Subp. 2. **Financial information.** Financial information for the financial and statistical report must include:

A. A statement of total net patient receipts for the health care provider, and by type of payer including Medicare, medical assistance and general assistance medical care, MinnesotaCare, children's health plan, other public payers, commercial insurers, nonprofit health plans, health maintenance organization, and consumer out-of-pocket expenses.

B. A statement of other operating revenue for the health care provider, including revenue for and from research and education, donations, grants, subsidies, and contractual agreements.

C. A statement of discounts and allowances including bad debt and charity care.

D. A statement of direct patient care expenses for the health care provider, including salaries and wages, employee benefits, purchased services and other health care costs, and malpractice insurance.

E. A statement of total administrative expenses for the health care provider, and for each of the following functions as defined in part 4651.0100 [Emergency]: admitting; billing and data processing; quality assurance; regulatory and compliance reporting; selling and promotion; general administration; government relations; research program expenses and education program expenses; fees; and taxes and assessments. The statement required by this item may be estimated from existing accounting methods with allocation to specific categories based on a written methodology that is available for review by the commissioner and that is consistent with the methodology described in this part.

Subp. 3. **Statistical information.** Statistical information for the financial and statistical report must include:

A. The number of patients or encounters for the health care provider, broken down by whether the person is a Minnesota resident or non-Minnesota resident, and by type of payer, including Medicare, medical assistance and general assistance medical care, MinnesotaCare, children's health plan, other public payers, commercial insurers, nonprofit health plans, health maintenance organizations, and consumer out-of-pocket expenses.

B. The total number of full-time equivalent employees for the health care provider and by type of employee, including physicians, physician assistants, nurse practitioners, nurse-midwife, registered nurses, licensed practical nurses, other nurses, other allied health providers, and administrative staff.

C. The type of ownership of the health care provider.

D. The name and specialty field of providers furnishing services at the health care provider's facility.

Subp. 4. **Additional information.** The report must include the following additional information:

A. the type of accounting method used by the health care provider; and

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B. certification by the governing authority of the health care provider's facility or its designee that the contents of the report are true.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0130 [Emergency] PROVISIONS FOR FILING REPORTS.

Subpart 1. **Forms to be specified.** Health care providers must file the information required by part 4651.0120 [Emergency] using the forms, instructions, and definitions designed and issued by the commissioner.

Subp. 2. **Filed personally.** Documents may be filed personally or delivered to the commissioner at the department's official offices during normal business hours.

Subp. 3. **Record complete.** No report required by this chapter is considered to be filed until the commissioner has determined that the report is complete according to part 4651.0170 [Emergency], subpart 1.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0140 [Emergency] FILING OF FINANCIAL AND STATISTICAL REPORT.

Subpart 1. **Filing report.** A health care provider must file with the commissioner a financial and statistical report, as required by part 4651.0120 [Emergency], by February 15, 1994, for the period July 1, 1993 to December 31, 1993, and by February 15 of each successive year, for the preceding calendar year.

Subp. 2. **Failure to file.** A health care provider that fails to file a financial and statistical report, and that has not requested an extension of time under part 4651.0160 [Emergency] to file that report, is in violation of parts 4651.0120 to 4651.0170 [Emergency].

A. The health care provider may be charged with a fine, as authorized by Minnesota Statutes, section 62J.35, subdivision 2. The fine shall be the lesser of $100 or 0.01 of its net receipts.

B. The health care provider shall not amend or modify its rates until after it files a report with the commissioner, and the report is considered to be complete as specified in part 4651.0170 [Emergency], subpart 1.

C. The health care provider shall be liable for the cost of a full audit by an independent public accountant, as necessary for the completion of the report.

D. The health care provider shall be subject to other disciplinary or regulatory actions until the report is complete, including revocation of license. The commissioner may obtain a court order requiring the provider to produce documents and allowing the commissioner to inspect the records of the provider for purposes of obtaining the data required.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0150 [Emergency] FILING OF REPORT BY A CLINIC.

Health care providers organized as a clinic, as defined by part 4651.0100 [Emergency], subpart 9, must file the report required under part 4651.0120 [Emergency] for the clinic.

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A corporation or organization operating more than one clinic may act as the organization that reports for the clinic to the commissioner.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0160 [Emergency] FILING OF REPORTS; EXTENSIONS.

A health care provider that shows reasonable cause may obtain from the commissioner an extension to file the financial and statistical report. The health care provider must provide the commissioner with a written request for an extension to file, specifying the reason or reasons for the requested extension, and the proposed date for filing the report. "Reasonable cause" means that the facility can demonstrate that compliance with the reporting requirements imposes an unreasonable cost to the facility, or that technical or unforeseen difficulties prevent compliance.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

4651.0170 [Emergency] REVIEW OF REPORTS.

Subpart 1. **Completeness.** The commissioner shall review each report required by part 4651.0120 [Emergency] in order to ascertain that the report is complete. If the report is found to be complete or if the commissioner has not notified the health care provider within 30 days of receiving the report that the report is incomplete, then the report is deemed to be filed as of the day it was received. "Complete" means that the report contains adequate data for the commissioner to begin the review and is in a form determined to be acceptable by the commissioner according to parts 4651.0120 to 4651.0140 [Emergency].

Subp. 2. **Incomplete report.** A report determined by the commissioner to be incomplete must be returned to the health care provider with a statement describing the report's deficiencies. The health care provider must resubmit an amended report to the commissioner. If the report is resubmitted within 14 days and is determined to be complete by the commissioner, then it shall be deemed to be filed as of the day it was first received by the commissioner.

Subp. 3. **Amending reports.** If a health care provider discovers any error in its statements or calculations in any of its submitted reports ascertained by the commissioner to be complete, it must inform the commissioner of the error and submit an amendment to the report.

Subp. 4. **Error in reports.** If the commissioner discovers a significant error in the statements or calculations in a report, the health care provider may be required to amend and resubmit the report by a date determined by the commissioner.

Subp. 5. **Timely.** "Timely" means that the report has been submitted within the time prescribed by part 4651.0140 [Emergency]; that an extension of this reporting time, as permitted by part 4651.0160 [Emergency], has not been necessary; and that the report has been determined to be complete under subpart 1.

Statutory Authority: *MS s 62J.35*
History: *18 SR 1570*

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4651.0180 [Emergency] OFFICIAL OFFICES.

For purposes of parts 4651.0100 to 4651.0170 [Emergency], the official office of the commissioner of health is: Minnesota Department of Health, 717 Delaware Street Southeast, Minneapolis, Minnesota 55414.

Statutory Authority: *MS s 62J.35*

History: *18 SR 1570*

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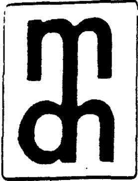
Appendix C



Minnesota Department of Health
717 Delaware Street Southeast
P.O. Box 9441
Minneapolis, MN 55440-9441
(612) 623-5000

December 20, 1993

Dear Administrator:

As part of the MinnesotaCare legislation of 1993, the Minnesota Department of Health is required to document and monitor all health care expenditures in the State (Article 3, section 12, of Minnesota Laws 1993, Chapter 345). This data collection effort requires health care providers to submit specific data related to health care revenues/receipts, expenditures and patient/encounter data by state residency.

The data required from physician clinics includes aggregate data for the last six months of calendar year 1993, on revenues by payer, expenditures and information about the number of patients or encounters by Minnesota and non-Minnesota residents. The form requests, at your option, data for the entire calendar year.

Enclosed please find a copy of the final survey forms along with instructions and definitions. These final forms have been developed from input we have received from numerous clinics during the last five months who are participating in this data collection process. These official forms must be completed and returned by February 15, 1994, unless you file for an extension from the Commissioner.

Your participation in the development of this process during the last few months has been extremely valuable in developing this final form. In addition, your participation will further the implementation of the reform initiatives developed by the Minnesota Health Care Commission, the legislature, and Governor Carlson to contain the increase in health care costs and to develop better data about the health care system. On behalf of the Department, I thank you for you input in this process and for your cooperation.

We look forward to working with you in this data collection process and receiving your surveys in February 1994. Please call Jerry Dalnes of our staff at (612) 282-6312 if you have any questions.

Sincerely,

Mary Jo O'Brien

Mary Jo O'Brien
Commissioner

MJO:JD

Enclosures

MINNESOTA DEPARTMENT OF HEALTH PHYSICIAN CLINIC SURVEY

(Completion and submission of this survey is required by Minnesota Laws Chapter 345, Article 3, Section 12)

STATISTICAL/DEMOGRAPHIC DATA

Facility/Organization Name and Address: County:

Federal Tax I.D. Number/EIN:

Phone Number:( )

Please attach list of satellite clinics

TYPE OF CLINIC

____ Corporation ____ Partnership ____ Sole Proprietor

REPORTING PERIOD

I am reporting financial data for the period:

_______ July 1, 1993 through December 31, 1993 (required)

_______ January 1, 1993 through December 31, 1993 (optional)

NAMES OF PHYSICIANS FURNISHING SERVICES AT THE CLINIC:

	Names	Specialty	UPIN & MN Physician License Number
A.			
B.			
C.			

Please atttach list if more space is needed.

FTE'S (Full Time Equivalents)

Physicians	_______
Physician Assistant	_______
Nurse Practitioners/Nurse Mid Wife	_______
RN's	_______
LPN's	_______
Other Nurses	_______
Other Allied Health Providers	_______
Physicians Services Under Agreement	_______
Administrative Staff	_______
Other	_______
TOTAL FTE's	_______

To the best of my knowledge and belief it is true in accordance with applicable instructions, except as noted.

_______________ (Signature) _______________ (Title) _______________ (Date)

Please Return this survey by February 15, 1994 to:

Attn: Jerry Dalnes
Minnesota Department of Health/HCDS
P.O. Box 64975
St. Paul, MN 55164-0975
(612) 282-6312

MINNESOTA DEPARTMENT OF HEALTH PHYSICIAN CLINIC SURVEY

(Completion and submission of this survey is required by Minnesota Laws Chapter 345, Article 3, Section 12)

Facility / Organization Name ______________________________

	NET PATIENT REVENUES/RECEIPTS	Total $$
1	Medicare ____ Par. ____ Non-Par	
2	Medical Assistance (MA), (GAMC) and Minnesota Care/Children's Health Plan	
3	Other Public (Describe)	
4	Commercial Insurers/BCBS	
5	HMO/PPO	
6	Out-Of-Pocket (Self-Pay)	
7	Sub-Total	

	Other Operating Revenue	Total $$
8	Research	
9	Education	
10	Donations/Grants/Subsidies	
11	Contractual Agreements	
12	Other	
13	Sub-Total	

14	Total Revenues	

Uncompensated/Discounted Care & Bad Debt

$$

Check One:
Total Number of Patients ______ or;
Total Number of Encounters ______

MINNESOTA RESIDENTS	NON-MINNESOTA RESIDENTS

Type of accounting method used:

______ Accrual ______ Cash ______ Modified Cash

* Optional *

Disallowed Charges and/or Contractual Adjustments

$$

MINNESOTA DEPARTMENT OF HEALTH PHYSICIAN CLINIC SURVEY

(Completion and submission of this survey is required by Minnesota Laws Chapter 345, Article 3, Section 12)

Facility / Organization Name ______________________________

	Direct Patient Care Expenses	TOTAL
1	Salaries/Wages for Health Care Professionals	
2	Employee Benefits for Health Care Professionals	
3	Purchased Services/Other Health Care Costs	
4	Malpractice Insurance	
5	Sub-Total	

	Operating/Administrative Expenses	TOTAL
6	Billing&Collections	
7	Admissions/Patient Registration	
8	Government /Internal Reporting Requirements	
9	Utilization Review/Regulatory Compliance	
10	Professional Fees/Association Fees	
11	Research	
12	Education	
13	General Administration	
14	Selling/Marketing	
15	Other	
16	Sub-Total	

17	**TOTAL EXPENSES**	

1) Time spent to complete this survey __________(Hrs) __________(Min)

2) Please attach your comments regarding this survey (improvements, complaints, etc...)

3) Did you receive outside assistance in completing this survey (i.e. consultants, accountants, etc...). _____YES _____ NO

INSTRUCTIONS AND DEFINITIONS FOR COMPLETING REVENUE CLASSIFICATIONS SECTION OF PHYSICIAN CLINIC SURVEY

Under Minnesota Laws chapter 345, article 3, section 12, providers are required to collect and submit to the commissioner of health data on revenues/receipts and expenses.

Below is a list of definitions to be used for classifying these revenues/receipts on page 2 of the attached survey.

Definition of Health Care Receipts (Page 2 of Survey)

Receipts should be either stated at total charges less disallowed amounts and bad debts for all of the payer categories listed below for using an accrual type of accounting method or if you are stating receipts using a cash basis, only state actual receipts for the reporting period.

Line One (1)

Medicare:

In this column, record all Medicare revenues/receipts and check off whether your organization is participating or non-participating with Medicare.

Line Two (2)

Medical Assistance/General Assistance/MNCare/CHP:

In this column, record all net revenues/receipts collected for Medical Assistance (MA), General Assistance (GAMC) and MinnesotaCare/Children's Health Plan.

Line Three (3)

Other Public:

This includes all revenue/receipts received for providing health care under programs like CHAMPUS, Head Start, other public health programs, etc... which was provided in the clinic.

Line Four (4)

Commercial Insurance/BCBS:

This includes total revenues/receipts received from commercial insurers for covered medical care services.

Line Five (5)

HMO/PPO:

This includes total revenues/receipts received from health maintenance organizations, preferred provider organizations, or other managed care entities.

Line Six (6)

Out-of-Pocket (Self-Pay):

This includes revenues/receipts received from patients for deductibles, co-payments and for services not covered by insurance or services not paid in other categories.

Line Seven (7)

Sub-Total:

Add lines one (1) through six (6) and place this sum on line seven (7).

Line Eight (8)

Research:

This includes all revenues/receipts associated with the planned search or critical investigation aimed at the discovery of new knowledge which will be useful in developing a new product or process, or in bringing about a significant improvement to an existing product or process. Research may be conducted with or without the involvement of a patient or patients.

Line Nine (9)

Education:

This includes revenues/receipts from entities, public or private, to provide education to health care professionals. Including tuition, fees, etc...

Line Ten (10)

Donations/Grants/Subsidies:

This includes revenues/receipts received from any individual, group, foundations and corporate donors other than revenue received for the purposes of either research, education or restricted gifts.

Line Eleven (11)

Contractual Agreement:

This includes revenues/receipts for outside contractual agreements which the clinic may have for delivering health care services for other than its own patients.

Line Twelve (12)

Other:

This includes revenues/receipts from copying medical records, legal reviews, parking fees, cafeteria, vending commissions, and other revenues which were not captured in the above categories.

Line Thirteen (13)

Sub-Total:

Add lines eight (8) through twelve (12) and place on line thirteen (13)

Line Fourteen (14)

Total Revenues:

Add up the total amounts from lines seven (7) and thirteen (13) and place on line fourteen (14). (Line 7+Line 13).

Uncompensated/Discounted Care & Bad Debt

This section on page one (1) of the clinic revenue survey is for clinics to report uncompensated/discounted care and care for which no payment was received (bad debt) during the reporting period. The definitions for these lost revenues are listed below.

Uncompensated Care/Discounted Care:

This includes the total amount of dollars charged and written off for care provided to uninsured patients or underinsured patients who cannot pay for the medical care received. This does not include professional courtesy discounts. Discounted care includes the total amount of dollars partially written off for uninsured/underinsured individuals who cannot pay for total charges billed based on factors such as limited income, unusual circumstances, or any other discounted service.

Bad Debt:

This expense category should reflect the actual amounts of charges that were not collected from patients who were considered as patients with ability to pay, after being discounted due to contractual obligations or other reasons.

Number of Patients by residency status :

In this section of page one (1) of the survey please list the number of unique patients Minnesota versus non-Minnesota residency status, and place the total at the bottom of page one (1) in the Total patients column. For further clarification, a "unique" patients is someone who was seen at least once during the reporting period. That is, if you saw that patient more than one time during the reporting period, you would only count that individual once.

OR;

Number of Encounters by residency status:

If you cannot provide the number of unique patients currently being seen, you may list the number of patient encounters by Minnesota or non-Minnesota residency. Please count the number of visits or procedures provided as a service to a patient and for which the provider can bill the patient or third party payer, including any procedure code in the Current Procedure Terminology, or any other billing code system, for the reporting period.

*** OPTIONAL ***

Disallowed Charges and/or Contractual Adjustments:

Place the total amount of dollars billed but not received due to contractual adjustments or disallowed amounts written off in this category. Note: This is an optional category for your organization to complete. You do not have to report your write-offs if you choose not to.

INSTRUCTIONS AND DEFINITIONS OF EXPENSE CLASSIFICATIONS FOR COMPLETING SURVEY OF EXPENSES FOR PHYSICIAN CLINICS

Under Minnesota Laws chapter 345, article 3, section 12, providers are required to collect and submit to the commissioner of health data on revenues and expenses for the reporting period.

Below is a list of definitions and instructions to be used for classifying these expenses on page 3 of the attached survey. When completing this survey, please round off to whole numbers with no cents.

<u>DIRECT PATIENT CARE EXPENSES:</u> (Page 3 of the survey)

Line One (1)

Salaries/Wages for Health Care Professionals:

This includes salaries, fees, commissions and other forms of compensation paid to physicians, non-physician providers; including audiologists, mid-wives, nurse practitioners, optometrists, physician assistants, podiatrists, psychologists, therapists, social workers and other individuals in related positions who can provide medical care and bill for services without continuous supervision by a physician. Registered nurses, triage nurses, licensed practical nurses, medical assistants, nurses aides, and other nursing support personnel. Laboratory personnel, radiology and imaging personnel. Physical therapy and optical personnel. Certified Nurse Anesthetists and ancillary services such as electrocardiography, electroencephalography, pulmonary function.

Line Two (2)

Employee Benefits for Health Care Professionals:

These benefits may include hospitalization insurance, medical and dental benefits, Worker's Compensation, employee life insurance, disability insurance, payroll taxes, F.I.C.A., annuity premiums, past service benefits and retirement account contributions.

Line Three (3)

Purchased Services/Other Health Care Costs:

This includes expenses for medical supplies, transportation of health care staff, depreciation costs of medical equipment (movable or non-movable), medical equipment purchases, information and communications systems that support health care professionals directly, patient education material (printed or in video), medical waste disposal, microfiche costs, uniforms, linen service, continuing medical education, continuing nursing education, allocated exam room rent expense, and other necessary direct patient care expenses.

Line Four (4)

Malpractice Insurance:

This includes total costs for professional liability insurance and tail coverage for health care providers, as well as self insured reserves.

Line Five (5)

Sub-Total:

Add lines one (1) throgh four (4) and place this sum on line five (5).

OPERATING/ADMINISTRATIVE EXPENSES:

This data is collected so that administrative processes and functions are measured, expenses due to these functions by years is monitored, and the impact of reform measures aimed at producing cost-savings and efficiencies within the system can be determined. These administrative expenses may be allocated by FTEs performing these specific categorical tasks, and the associated costs in these areas. Or these costs may be allocated on a percentage basis or by square footage when allocated costs for space.

Line Six (6)

Billing and/or Collections:

This includes all costs that are directly incurred as a result of, or while performing the various functions involved in the process of billing and/or collections. This includes all compensation (wages and benefits) for personnel time devoted to, or in direct support of the receipt and handling, collection, data entry, processing and editing, and posting payment and final disposal of the claims/bills. Direct expenses also include all expenses related to the electronic processing of these claims (such as computer-related expenses).

When possible, computer expenses should be allocated by time, resource utilization, or other means, to the other administrative and non-administrative functions. If allocation is not possible, all computer costs should be reported under this line-item.

Line Seven (7)

Admissions/Patient Registration/Scheduling/Medical Records:

This includes all costs which are incurred for medical receptionists, medical records, medical transcriptionists, scheduling systems staff directly supporting health care professionals.registering, scheduling and maintaining the medical records for patient visits in the delivery of health care services. These visits could be for visits within the health clinic or for visits outside the clinic, but have occurred incident to a provider's request.

Line Eight (8)

Government Reporting Requirements:

This includes all direct costs associated with, or directly incurred in the preparation and filing of financial, statistical or other utilization reports required by federal, state, county and local governments.

Internal Reporting Requirements:

This includes all direct costs associated with staff time to collect, prepare and present reports to management and other non-government related business.

Line Nine (9)

Utilization Review/Regulatory Compliance:

This includes all direct expenses associated with any activity or program established for the purpose of utilization review, monitoring regulatory compliance and quality assurance of care evaluation. Direct expenses include compensation (wages/benefits) for personnel time devoted to, or in direct support of such activities as utilization review, peer review, quality assurance, quality improvement and all other medical care evaluation activities, and the communication of information regarding these activities. Direct expenses also include all professional fees, supplies, purchased services, and any other resource used in accomplishing these activities.

Line Ten (10)

Professional Fees/Association expenses:

This includes all professional affiliations, dues paid for association membership and physician licenses.

Line Eleven (11)

Research expenses:

This includes all costs associated with the planned search or critical investigation aimed at the discovery of new knowledge which will be useful in developing a new product or process, or in bringing about a significant improvement to an existing product or process. Research may be conducted with or without the involvement of a patient or patients.

Line Twelve (12)

Education expenses:

This includes all costs incurred for educational programs, including continuing education programs, community education programs, as well as educational programs for medical support staff and administrative staff.

Line Thirteen (13)

General and Administration Expenses:

This includes all costs associated with the overall management and administration of the organization, such as costs of governing boards, auxiliary groups, public relations and development (excluding government relations), management engineering, purchasing, communications.

It also includes all costs unless included elsewhere which are related to fiscal services, such as general accounting, budgeting and costs, payroll accounting, accounts payable, plant and equipment, and inventory accounting. Include any expense in this category which was not listed above.

Line Fourteen (14)

Selling & Marketing:

This includes all direct expenses related to marketing activities such as advertising, printing, marketing representative compensation and fringe benefits, commissions, broker fees, travel, occupancy, and other expenses allocated to the marketing activity.

Line Fifteen (15)

Other administrative costs:

This include all costs related to other administrative functions, and that are not included in the above categories. Examples may include printing and duplicating, receiving and storing, and personnel management.

Line Sixteen (16)

Sub-Total:

Total lines six (6) through fifteen (15) and place this sub-total on line sixteen (16).

Line Seventeen (17)

Total Expenses:

Add the sub-totals of lines five (5) and sixteen (16); place that total amount on line seventeen (17). (Line 5 + Line 16).

Appendix D

Chapter 4651 - Aggregate Data from Providers

Andrew Calkins (4650 & 4651)
Minnesota Nurses Assn
1295 Bandana Blvd. N, Suite 140
St. Paul, MN 55108-5115
Ph: 646-4807
Fx: 646-4807

Jerry Dalnes (MDH - 4651)
MN Dept of Health
Metro Square Bldg, Suite 400
121 East Seventh Place
St. Paul, MN 55101
Ph: 282-6312
Fx: 282-5628
Internet: jerry.dalnes@health.state.mn.us

Kerry Durkin (4651)
Fairview Hospital and Healthcare Services
600 West 98th Street
Suite 390
Bloomington, MN 55420
Ph: 885-6208
Fx: 885-6206

Robert Elson, M.D. (4651)
Univ of MN, Medical School
Box 511
420 Delaware Street S.E.
Minneapolis, MN 55455
Ph: 625-3246
Fx: 625-7166
Internet: relson@staff.tc.umn.edu

Tim Geisler (4651)
Mayo Foundation
Ozmund Building
Rochester, MN 55902
Ph: 507/284-5752
Fx: 507/284-0986

Dr. Christine Goertz (4651)
Minnesota Chiropractic Assn
1837 Franklin Ave SE
Minneapolis, MN 55414
Ph: 624-8952
Hm: 379-2515
Fx: 624-2196

Cletis Hoffer (4651)
Progressive Healthcare
4900 Lincoln Dr
Edina, MN 55436
Ph: 933-5357
Fx: 933-0471

Dr. Douglas Keim (4651)
Minnesota Dental Assn
2233 Hamline Ave N, # 210
St. Paul, MN 55113
Ph: 631-2944
Fx: 639-1439

Charles Munster (4651)
Minnesota Otolaryngology
Meadowbrook Medical Building
6490 Excelsior Blvd., Rm. W-311
St. Louis Park, MN 55426
Ph: 925-5626
Fx: 925-0223
Internet: 74204.1646@CompuServe.com

Dave Orren (MDH Staff for TF & WGs)
MN Dept of Health
Metro Square Bldg, Suite 400
121 East Seventh Place
St. Paul, MN 55101
Ph: 282-6310
Fx: 282-5628
Internet: david.orren@health.state.mn.us

Trisha Schirmers (4650 & 4651)
HealthSpan
Abbott Northwestern Hospital, #13502
800 East 28th Street
Minneapolis, MN 55407
Ph: 863-4782
Fx: 863-3376

Timothy Schmidt (4651)
Lurie, Besikof, Lapidus, and Company
2501 Wayzata Boulevard
Minneapolis, MN 55405
Ph: 377-4404
Fx: 377-1325

Janet Silversmith (4651)
Minnesota Medical Assn
Broadway Place East
3433 Broadway Street NE, #300
Minneapolis, MN 55413
Ph: 378-1875
Fx: 378-3875

Mark Skubic (4650 & 4651)
HealthSystem Minnesota
P.O. Box 650
Minneapolis, MN 55440
Ph: 939-8610
Fx: 932-6490

Dawna Tierney (MDH - 4651)
MN Dept of Health
Metro Square Bldg, Suite 400
121 East Seventh Place
St. Paul, MN 55101
Ph: 282-6309
Fx: 282-5628
Internet: dawna.tierney@health.state.mn.us

Jim Tierney (4651)
Minnesota Medical Group Managers Assn
Suburban Radiology
4801 West 81st Street
Suite 108
Minneapolis, MN 55437
Ph: 831-7310
Fx: 831-2455

Terry Tone (TF & 4651)
Minnesota Medical Group Managers Assn
Owatonna Clinic
134 Southview
Owatonna, MN 55060
Ph: 507/455-4441
Fx: 507/451-8932

Kevin Walsh (4651)
HealthSpan
Abbott Northwestern Hospital, #13502
800 East 28th Street
Minneapolis, MN 55407
Ph: 863-5507
Fx: 863-3376

Debra Welle (4651)
HealthEast
559 Capitol Blvd
St. Paul, MN 55103
Ph: 232-2174
Fx: 232-2009

Interested Persons Mailing List

Sandy Abrams (All WGs)
MN Dept of Health
Metro Square Bldg, Suite 400
121 East Seventh Place
St. Paul, MN 55101
Ph: 282-6352
Fx: 282-5628
Internet: sandy.abrams@health.state.mn.us

Appendix E

Minutes from Permanent Rules Work Group (Health Care Providers) for Friday, March 3, 1994.

The work group began at appx. 12:00 (Noon)

Members present were:

Jerry Dalnes - Minnesota Department of Health
Kerry Durkin - Fairview
Bob Elson - University of Minnesota
Doug Keim - Minnesota Dental Association
Tim Geisler - Mayo Foundation
Christine Goertz - Minnesota Chiropractic Association
Chuck Munster - Minnesota Otolaryngology, P.A.
Dave Orren - Minnesota Department of Health
Tim Schmidt - Lurie, Besikof, Lapidus, and Company
Janet Silversmith - Minnesota Medical Association
Mark Skubic - HealthSystem Minnesota
Jim Tierney - Minnesota Medical Group Managers Association

Members absent:

Andrew Caulkins - Minnesota Nurses Association
David Doth - Metropolitan Healthcare Council
Terry Tone - Minnesota Medical Group Managers Association

The meeting began with the work group members going around the table and introducing themselves and giving a brief overview of their background.

Discussion then centered on the process on the writing of the permanent rules and what type of input will be required from the group.

The work group then moved on to the issues of data collection and reporting to the department. The issues and comments were varied and ranged across a wide spectrum. The topics which were discussed were:

- Legislative requirements
- Administrative Expenses
- Dates for reporting the information
- The reasons for needing the data by the department and how it will be used in helping create reform?
- Will other providers be affected by this process and when?
- Discussion of changing the data collection form

The work group asked the facilitator for the group to go back and look at the what the 1993 legislation says and begin drafting the statement of need and reasonableness for them to review at the next meeting on Thursday, March 17.

The group adjourned at 2:00 p.m.

Minnesota Department Of Health
Minutes for the Work Group on Chapter 4651
Aggregate Data from Providers
March 17, 1994, 8:30 - 10:30 a.m.
Minnesota Medical Association
Minneapolis, Minnesota
Working Notes

Work group members and other persons attending the meeting included:

Jerry Dalnes, Minnesota Department of Health
Kerry Durkin, Fairview Hospital and Healthcare Services
Tim Geisler, Mayo Foundation
Christine Goertz, Minnesota Chiropractic Association
Doug Keim, Minnesota Dental Association
Chuck Munster, Minnesota Otolaryngology, P.A.
Dave Orren, Minnesota Department of Health
Tim Schmidt, Lurie, Besikof, Lapidus, and Company
Janet Silversmith, Minnesota Medical Association
Jim Tierney, Minnesota Medical Group Managers Association
Kevin Walsh, HealthSpan
JoMarie Williamson, Minnesota Department of Health

Members absent:

Andrew Calkins, Minnesota Nurses Association
Bob Elson, University of Minnesota Medical School
Cletis Hoffer, Progressive Healthcare
Trisha Schirmers, HealthSpan
Mark Skubic, HealthSystem Minnesota
Terry Tone, Minnesota Medical Group Managers Association

The meeting began with introduction of new task force members and an update of the Task Force meeting on Administrative Costs, April 6th, at the Minnesota Department of Health from 8:30 to 11:30.

The first item of discussion was regarding the submission date for reporting data. It was voiced that February 15 is too soon after the calendar year. The group would like a date after April 15. It was explained that the legislature and the department were working to change the date to April 1.

Jerry then went on to discuss how he was drafting the Statement of Need and Reasonableness (SNR). It will be broken up into three sections. 1). Total Health Care Expenditure Monitoring, 2). Monitoring of total health care provider revenue limits, and 3). review of administrative expenditures by health care providers. Dave Orren will work with and review the development of the SNR.

The next item was what is the Department of Revenue doing? This question was puzzling and perplexing to the folks from the Department of Health and they asked if they could check with senior management and get an answer back to the group at the next meeting. The work group also wanted to know whether MDH will use the same definitions that the Department of Revenue uses for types of revenue.

The group then went on and discussed definitional issues, the main question was, "What is an encounter?" And how do we define/capture an encounter for capitated providers? The work group recommended the definitions of encounter from the emergency reules be rewritten as follows. "... ~~can bill the patient or third party payer~~ has a billing code..."

The last issue was a request by some members to have the statutory language in the document being reviewed for matters of convenience.

The next meeting is on Thursday, April 14, 1994 from 8:30 to 10:30 a.m. It will be at the Minnesota Medical Association Building located at 3433 Broadway Street NE, #300, Minneapolis, MN.

Minnesota Department Of Health
Work Group on Chapter 4651 - Aggregate Data from Providers
April 14, 1994, 8:30 - 10:30 a.m.
Minnesota Medical Association in Minneapolis, Minnesota
Working Notes

Work group members and other persons attending the meeting included:

Sandy Abrams, Minnesota Department of Health
Lynn Blewett, Minnesota Department of Health
Jerry Dalnes, Minnesota Department of Health
Kerry Durkin, Fairview Hospital and Healthcare Services
Tim Geisler, Mayo Foundation
Doug Keim, Minnesota Dental Association
Chuck Munster, Minnesota Otolaryngology, P.A.
Dave Orren, Minnesota Department of Health
Elisabeth Quam, Minnesota Department of Health
Trisha Schirmers, HealthSpan
Janet Silversmith, Minnesota Medical Association
Dawna Tierney, Minnesota Department of Health
Jim Tierney, Minnesota Medical Group Managers Association
Terry Tone, Minnesota Medical Group Managers Association
Kevin Walsh, HealthSpan
Debra Welle, HealthEast
JoMarie Williamson, Minnesota Department of Health

Members absent:

Andrew Calkins, Minnesota Nurses Association
Bob Elson, University of Minnesota Medical School
Christine Goertz, Minnesota Chiropractic Association
Cletis Hoffer, Progressive Healthcare
Tim Schmidt, Lurie, Besikof, Lapidus, and Company
Mark Skubic, HealthSystem Minnesota

The regular meeting of the work group was convened at 8:30 a.m.

Discussions began with a review of the minutes from the meeting on March 17th. Dave Orren reviewed what was discussed at the Administrative Costs Task Force meeting on March 3rd. He explained that the work groups would have the opportunity to develop their own categories which were appropriate to their organizations and would have to account for their health care expenditures.

The first point of discussion was the negative tone of administrative costs. The group felt that it would be better to drop administrative costs and just call this section of the survey Expenses. In addition the group felt that breaking out expenses into direct patient care categories and other administrative categories was not necessary. The new format will just have specific expense category labels with the definitions specifically directing what expenses

to allocate into the seperate categories. It was felt that reporting expenses in this manner was a more rational and understandable way of reporting health care provider expenses. Other concerns expressed by the work group was how the legislature would perceive the data in aggregate.

The idea of having four expense categories was tossed around the group. The four categories would be:

Direct Expenses
Indirect Expenses
Administrative Expenses
Research/Health & Wellness Expenses

This breakdown was later dropped as an option for the providers to report this way.

The group then began to discuss each of the expense categories and here is a list of what was decided.

Combine lines #1 & #2 from the old survey and just combine
Leave the malpractice expense line in
Leave in billing and collections with an area to check off if manual or automated
Expand patient registration, scheduling and admissions into one line
Delete the UR/QA line
Leave research expense line in
Expand the Education expense line to three lines. The three lines being:
- Education - Degree programs
- Patient/Public Health Education
- Education - Other

Delete General Administration and combine with Other Expenses categories
Change the Selling/Marketing category to Promotion & Marketing
Add another category to report MinnesotaCare tax
Leave Other expenses in

The workgroup felt that these categories were much more representative for their particular industry and with clearer definitions the aloocating expenses into these categories will make the process a little easier.

It was explained to the workgroup that there would be no way for the department to come in at a later date and verify whether the expense allocation was reasonable or unreasonable.

The after these categories were re-defined the group went back and reviewed the definitions for each of the categories.

The first category of health care professional costs would include all expenses related to health care professionals and allied health care professionals. Some of these expenses would be salary, benefits, commissions, profit sharing, FICA, payroll taxes, etc...

The second category concerning other health care costs dealth with costs related to the provision of care to patients, excluding personnel costs.

The third expense area covered was malpractice. The issue arose about how do self-insured plans account for this. It was decided to add additional language in the definition about self-insured organizations.

The fourth category as previously defined was acceptable to the workgroup members.

The fifth category of patient registration, scheduling and admissions was updated in the definition to assist organizations in seperating out costs not related to direct patient care mentioned in the first two categories (i.e. health care professional costs and other health care costs).

The sixth category of Financial, Accounting and Reporting expenses was expanded to pick-up the accounting functions which were moved from the general administration category which was removed.

The seventh category of research was reviewed and the work group was willing to keep the current definition because many of the providers do not directly receive medical research revenues.

In the eighth category there was discussion of breaking down education into degree and non-degree categories. It was decided by the group to go back and review this further at the next meeting on April 21st.

The meeting was adjourned at 11:00 a.m. and an additional meeting was scheduled for Thursday, April 21.

Minnesota Department Of Health
Work Group on Chapter 4651 - Aggregate Data from Providers
May 19, 1994, 8:30 - 10:30 a.m.
at Minnesota Medical Association in Minneapolis, Minnesota
Working Notes

Work group members and other persons attending the meeting included:

Jerry Dalnes, Minnesota Department of Health
Kerry Durkin, Fairview Hospital and Healthcare Services
Tim Geisler, Mayo Foundation
Christine Goertz, Minnesota Chiropractic Association
Chuck Munster, Minnesota Otolaryngology, P.A.
Dave Orren, Minnesota Department of Health
Trisha Schirmers, HealthSpan
Janet Silversmith, Minnesota Medical Association
Dawna Tierney, Minnesota Department of Health
Jim Tierney, Minnesota Medical Group Managers Association
Kevin Walsh, HealthSpan
JoMarie Williamson, Minnesota Department of Health

Members absent:

Andrew Calkins, Minnesota Nurses Association
Bob Elson, University of Minnesota Medical School
Cletis Hoffer, Progressive Healthcare
Doug Keim, Minnesota Dental Association
Tim Schmidt, Lurie, Besikof, Lapidus and Company
Mark Skubic, HealthSystem Minnesota
Terry Tone, Minnesota Medical Group Managers Association
Debra Welle, HealthEast

Appendix F

Table 4.17

Estimated Annual Receipts of Health Services Businesses, 1985–1991 (Millions)

Type of Business	1985	1986	1987	1988	1989	1990	1991
Health services (all)	$147,415	$161,882	$182,289	$203,364	$219,081	$243,048	$261,269
Offices and clinics of doctors of medicine	72,065	78,360	90,462	100,314	106,300	115,067	122,470
Offices and clinics of dentists	20,574	21,901	24,017	25,550	26,932	28,475	29,731
Offices and clinics of doctors of osteopathy	1,765	1,938	2,119	2,335	2,321	2,513	2,599
Offices and clinics of other health practiitoners	7,864	8,791	10,340	12,167	12,795	14,802	15,628
Offices and clinics of chiropractors	2,678	3,005	3,275	3,984	4,420	4,828	4,986
Offices and clinics of optometrists	2,818	3,038	3,450	3,760	3,864	4,275	4,430
Offices and clinics of podiatrists	NA	NA	NA	NA	NA	1,689	1,826
Nursing and personal care facilities	17,462	19,040	20,063	21,361	23,349	26,446	28,848
Skilled nursing care facilities	NA	NA	NA	NA	NA	21,790	23,623
Intermediate care facilities	NA	NA	NA	NA	NA	2,998	3,338
Nursing and personal care facilities	NA	NA	NA	NA	NA	1,658	1,887
Hospitals	15,724	18,068	19,720	22,777	25,023	29,059	31,523
General medical and surgical hospitals	NA	NA	NA	NA	NA	22,579	24,518
Psychiatric hospitals	NA	NA	NA	NA	NA	2,095	5,436
Specialty hospitals, except psychiatric	NA	NA	NA	NA	NA	1,385	1,569
Medical and dental laboratories	5,381	6,057	7,114	8,119	8,933	9,872	10,527
Medical laboratories	3,895	4,455	5,518	6,620	7,374	8,209	8,849
Dental laboratories	1,486	1,602	1,596	1,499	1,559	1,663	1,678
Home health care services	NA	NA	NA	NA	NA	6,196	7,381
Miscellaneous health and allied services	NA	NA	NA	NA	NA	10,618	12,562
Kidney dialysis centers	NA	NA	NA	NA	NA	1,272	1,505
Specialty outpatient facilities	NA	NA	NA	NA	NA	5,258	6,426

NOTE. Data reflects taxable firms. Taxable firms were considered by definition of federal income tax.
NA: Not available.
SOURCE: Health Services; U. S. Department of Commerce, Bureau of the Census.

Appendix G

Table 1B: Staffing per FTE Physician for Multispecialty Groups

1992 Data

Staffing Variables	Group Type							
	Multispecialty							
	Count	Mean	Std. Dev.	10th %tile	25th %tile	Median	75th %tile	90th %t
TOT. FTE NONPROV. PER FTE PHY.	350	4.51	1.51	2.72	3.78	4.50	5.32	6.2
Administrative	317	.25	.21	.10	.14	.20	.30	.4
Business office	308	.71	.32	.36	.50	.67	.86	1.0
Information services	222	.19	.11	.08	.11	.17	.23	.3
Housekeeping/main./security	212	.17	.16	.04	.08	.14	.22	.3
Other admin. support	183	.18	.24	.03	.05	.10	.26	.4
Registered nurses	270	.49	.36	.09	.22	.40	.70	1.0
LPNs, medical assistants, etc.	287	.93	.50	.40	.59	.86	1.15	1.5
Medical receptionists	297	.66	.33	.27	.43	.63	.83	1.0
Med. secretaries/transcribers	289	.31	.24	.10	.17	.28	.36	.5
Medical records	275	.37	.19	.16	.25	.35	.47	.6
Laboratory	263	.36	.17	.15	.25	.34	.43	.5
Radiology/imaging	264	.25	.14	.09	.15	.22	.31	.4
Physical therapy	80	.11	.09	.03	.04	.08	.14	.2
Optical	83	.07	.07	.02	.04	.05	.08	.1
Cert. reg. nurse anesthetists	33	.11	.09	.03	.05	.09	.13	.1
Other med./ancill. services	175	.33	.53	.05	.09	.17	.35	.6
TOTAL FTE AHP PER FTE PHY.	245	.36	.85	.04	.09	.16	.26	.4
NUMBER OF FTE PHYSICIANS	371	47.05	172.56	7.00	12.00	21.50	40.00	90.8

Notes: An asterisk indicates that data are suppressed when the count (number of responding groups) is less than 10. A zerc a count column indicates that the count is less than 10.