# Center for Health Care Purchasing Improvement (CHCPI)

# Annual Report

## (January 2010 - December 2010)

*Report to the Minnesota Legislature 2010*

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## Minnesota Department of Health

**May 2011**

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## May 2011

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# Center for Health Care Purchasing Improvement (CHCPI) Annual Report

(January 2010 – December 2010)

**Summary**

## Overview

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) for the period January to December 2010 is being submitted to the Governor and Legislature as required by Minnesota Statutes, section 62J.63.

The Center is a section within the Minnesota Department of Health (MDH) that serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services" and in achieving other related health care system improvement goals. In mid-2007 CHCPI was selected to manage the multi-year development and implementation of first-in-the-nation state requirements to automate and simplify several high volume, routine health care business transactions, effective in 2009. When fully implemented, the regulations will reduce overall health care administrative costs in Minnesota's health care system by a projected $40 to $60 million annually[i], allowing more of every health care dollar to be spent on patient care and health improvements. The state's requirements apply to over 60,000 health care providers in Minnesota and more than 2000 insurance carriers and other health care payers nationwide.

CHCPI works closely in partnership with the industry and stakeholders, particularly the Minnesota Administrative Uniformity Committee (AUC), a large, voluntary organization of health care providers, payers, health care associations, and state agencies working together to reduce health care administrative costs and burdens.

## Key impacts and benefits

During 2010 the Center continued to serve primarily as project manager in implementing state requirements to automate and streamline millions of common health care administrative transactions exchanged annually. While the initiative is still underway, its impacts are evident at this time in:

- Early indications of system-wide health care administrative efficiencies and cost reductions;
- Growing national recognition; and,
- Minnesota's opportunities to constructively contribute to and benefit from federal health care administrative simplification initiatives adopted as part of recent federal health reforms.

The remainder of this report describes CHCPI's activities and accomplishments during 2010 in more detail.

# Center for Health Care Purchasing Improvement (CHCPI)
# Annual Report

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## I. INTRODUCTION

### A. Annual Report

This annual report of the Center for Health Care Purchasing Improvement (CHCPI) encompasses the period from January to December, 2010. This report is being submitted to fulfill the requirements of Minnesota Statutes, section 62J.63, subdivision 3, that

*"The commissioner of health must report annually to the legislature and the governor on the operations, activities, and impacts of the center. The report must be posted on the Department of Health Web site and must be available to the public. The report must include a description of the state's efforts to develop and use more common strategies for health care performance measurement and health care purchasing. The report must also include an assessment of the impacts of these efforts, especially in promoting greater transparency of health care costs and quality, and greater accountability for health care results and improvement."*

### B. Background and Overview

### 1. Minnesota's health care context and challenges

It is a significant understatement to note that Minnesota's health care system, like the nation's generally, is large, complex, and expensive. In 2008, the most recent year for which data is available, expenditures in Minnesota's health care sector exceeded more than $35 billion.[ii] This level of spending represented over fourteen percent of the state's gross domestic product (GDP)[iii] – more than the value of Minnesota's agriculture and tourism industries combined.[iv] The State of Minnesota alone purchases health care services on behalf of over 942,000 Minnesotans at projected costs of more than $5.7 billion annually,[v] and health care costs are one of the most rapidly growing components of the state budget.

Despite the broad scope and significant cost of the health care system, a number of studies have characterized it as disjointed and fragmented. They cite variable or often poor quality overall, reflecting skewed payment incentives that do not align for optimum value and performance.[vi] At a more detailed level, even common, routine health care business transactions -- such as determining patient eligibility for insurance coverage and benefits, submitting bills to payers for reimbursement, and providing remittances to providers -- are often unnecessarily burdensome or expensive.[vii]

## 2. CHCPI purpose and current focus

### a. Overview

CHCPI was authorized and created in 2006 to help address systemic problems contributing to health care system underperformance. Pursuant to statute, CHCPI serves to "support the state in its efforts to be a more prudent and efficient purchaser of quality health care services." It is also authorized to participate in other related health care improvement activities, including reducing the costs and burdens of health care administration. A key CHCPI objective is to promote "common strategies and approaches"[viii] across diverse stakeholders to improve health care outcomes and to increase the value of every dollar spent on health care.

### b. CHCPI's current role in reducing health care administrative costs and burdens

#### *i. Background and context: Health care business transactions*

Nationally, health care payers process more than five billion claims (billings) annually.[ix] In Minnesota alone, the state's health plans processed more than 59 million health care claims in 2010.[x] Moreover, providers, payers, and venders exchange millions of other business transactions, including eligibility inquiries and responses, authorizations, and payments. Because of the high volume of these transactions, even small inefficiencies add up significantly and quickly as unnecessary costs and burdens.

This is especially the case when daily, ongoing business is not conducted using standard, automated, electronic data interchange (EDI). For example, a national actuarial firm found that it cost health care providers, on average, $3.73 more per claim to submit their bills on paper than to submit them electronically.[xi] The same actuarial firm found that insurers and other payers likewise pay more – in this case, an average of sixty cents more to receive a paper claim than when the same claim is sent electronically.[xii] Not only are these extra transaction costs not adding value, but they also displace valuable resources better used for patient care and improved health care outcomes.

#### *ii. Federal HIPPA regulations*

Despite the benefits of EDI, the health care industry has generally lagged behind the financial, transportation, and other sectors in automating routine business communications. The 1996 federal Health Insurance Portability and Accountability Act (HIPAA) was intended in part to remedy the problem by laying the foundation more efficient, electronic data exchange. For example, HIPAA required that health care payers accept certain electronic transactions from providers, and most providers also were required to submit their bills to Medicare electronically. HIPAA regulations further mandated that the electronic transactions adhere to standards developed by several specified national organizations.

HIPAA provided an important framework for quicker, less burdensome, more accurate communications of large amounts of industry data. However, the regulations were often not as specific and detailed as needed, resulting in variability and ambiguity in how data were to be

exchanged. In response, and to the extent allowed under HIPAA, health care payers often imposed their own requirements, with the specificity needed to conduct individual data exchanges. These individual payer overlays of the HIPAA requirements are known as "companion guides". The proliferation of many individual, idiosyncratic companion guides was permitted under HIPAA, but it eroded the regulations' effectiveness as a single, common standard for effectively and efficiently automating data flows.

*iii. Minnesota's administrative simplification initiative and CHCPI*

Minnesota addressed the problem of "nonstandard standards" with the enactment of Minnesota Statutes, section 62J.536 in 2007. The law and related rules requires that certain high volume health care business data be exchanged via a single, standard form of HIPAA-compatible EDI, using a single, uniform companion guide, effective 2009.

In mid-2007 CHCPI was selected to manage an extensive, multi-year rulemaking process for the single, uniform companion guides required under the statute, as well as the implementation and enforcement of the law and subsequent changes or refinements of the rules. Pursuant to statute, the Center partners closely in the development of the regulations with a large, voluntary stakeholder organization known as the Minnesota Administrative Uniformity Committee (AUC).

The state's rulemaking process relies on significant technical input from affected stakeholders, as well as substantial outreach and communication to inform health care providers, payers, and others of the legislation and rules, within a very short timeframe. This process has benefited greatly from the in-kind contributions of hundreds of hours of expertise provided by several dozen health care provider, payer, and other technical subject matter experts affiliated with the AUC and interested parties.

As discussed in more detail in the next section of the report, CHCPI's administrative simplification activities and priorities for 2010 were largely shaped by state and federal regulations. In particular, CHCPI worked closely with the AUC to update the state's administrative simplification rules in response to new, improved standards for the exchange of health care administrative transactions advocated by the industry nationally, and adopted at the federal level in 2009. During 2010, the Center also began preparing for significant additional administrative standardization and automation under federal health reform legislation enacted earlier in the year. As noted below, Minnesota's efforts are increasingly attracting national attention, allowing Minnesota to play a more active role in a variety of efforts designed to bring about greater health care administrative streamlining and cost reductions nationally.

A more detailed discussion of the rationale and policy framework for Minnesota's administrative simplification efforts, as well as a description of the rulemaking process and timelines pursuant to Minnesota Statutes, section 62J.536, have been presented in previous annual reports and is briefly summarized as Appendix 1 in this report.

## II. KEY CHCPI ACTIVITIES AND IMPACTS IN 2010

### A. Summary

As discussed below, during 2010 the Center served primarily as project manager in implementing state requirements to automate and streamline millions of common health care administrative transactions exchanged annually. While the initiative is still underway, its impacts are evident at this time in:

- Early indications of system-wide health care administrative efficiencies and cost reductions;
- Growing national recognition; and,
- Minnesota's opportunities to constructively contribute to and benefit from federal health care administrative simplification initiatives adopted as part of federal health reforms.

### 1. CHCPI project management to automate and streamline the exchange of health care administrative transactions

#### a. CHCPI provided extensive facilitation of an open, public rulemaking process in 2010

During 2010, the Center organized, staffed, and facilitated over 110 open, public meetings of the AUC and its Technical Advisory Groups (TAGs). As a result of this collaboration:

- MDH promulgated or adopted 20 sets of rules, providing greater clarification and consistency for the standard, electronic exchange of health care business data, and published additional recommended industry best practices and medical coding clarifications;
- CHCPI assisted the AUC in presenting Minnesota's perspectives and recommendations to the National Center on Vital and Health Statistics (NCVHS) and the federal Centers of Medicare & Medicaid Services (CMS) and other national organizations regarding emerging issues in national health care administrative simplification;
- CHCPI provided technical assistance and answers to questions for over 700 separate inquiries from stakeholders, the public, and private and public organizations.

#### b. CHCPI's focus and priorities during 2010 reflected state and federal regulations

*In completing the aforementioned tasks and objectives, CHCPI's focus for 2010 and its work with the AUC was heavily influenced by state and federal regulations. In particular, CHCPI's work reflected:*

*i. Amendments to Minnesota Statutes, section 62J.536 to include health care clearinghouses and the exchange of acknowledgement transactions;*

In 2009, CHCPI assisted in the development of an MDH legislative proposal to address concerns raised about the role of health care clearinghouses in the communication of health care administrative transactions. Clearinghouses serve as intermediaries between providers and payers to facilitate exchanges of data from one point to another. MDH's proposal expanded provisions of Minnesota Statute, section 62J.536, to include clearinghouses, and required that providers, payers, and clearinghouses exchange a version of an electronic receipt – or, acknowledgment -- when sending or receiving health care claims or remittances.

The proposal -- the first of its kind in the nation -- was enacted into law in April 2010, and required that MDH adopt rules for the automated exchange of electronic acknowledgments by the end of the year. CHCPI worked closely with the AUC to quickly and successfully promulgate and adopt the required rules on time.

*ii. Revisions to Minnesota's rules to comply with federal regulations;*

Minnesota's rules pursuant to Minnesota Statutes, section 62J.536, must comply with federal HIPAA regulations. In 2009, CMS adopted rules for the adoption of new, improved versions of the electronic exchange specifications. The new versions are known as "5010" and "D.0", and CHCPI again collaborated extensively with the AUC in 2009 to develop and refine Minnesota's rules to be compliant with the federal regulations 5010 and D.0. This activity continued during 2010 with additional state rulemaking and updates after CMS adopted additional clarifications and corrections of the 5010 standard.

*iii. Passage of significant administrative simplification as part of federal health care reform, the Patient Protection and Affordable Care Act (PPACA), enacted in 2010;*

Several other important federal laws and rules were enacted in late 2009 and 2010 with long term implications for Minnesota's administrative simplification goals. In particular, Section 1104 of the federal Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, requires the Secretary of the US. Department of Health and Human Services (HHS) to adopt and implement:

- operating rules, which are intended to complement and provide additional specificity for HIPAA transactions and code sets regulations;
- new HIPAA transactions standards; and,
- related compliance certification and enforcement over the next five years.

A brief summary of Section 1104 follows as Appendix 2.

During 2010 CHCPI outlined key provisions of Section 1104 with the AUC, began planning for possible next steps to ensure compliance with the Section, and assisted the AUC in responding to requests for comments and input regarding the federal requirements.

## 2. Impacts and benefits of Minnesota's administrative simplification efforts

### a. Early indications of system-wide health care administrative efficiencies and cost reductions

MDH estimates that when fully implemented, the initiatives undertaken as a result of Minnesota Statutes, section 62J.536 and related rules will reduce total health care administrative costs system-wide by a projected $40 to $60 million annually.[xiii] Although many of Minnesota's requirements had only recently taken effect in 2010, several early indicators of savings and efficiency gains became apparent. For example:

- The Minnesota Council of Health Plans reported that the rate of electronic health claims received by state health plans increased from 83 percent in 2007 to 93 percent in 2010.[xiv] Using conservative national estimates of potential cost savings from the increased electronic transactions, this increase in electronic claims alone corresponds to an estimated $25.5 million annual reduction in administrative costs across Minnesota's health care system.[xv]
- The Minnesota Department of Human Services (DHS) administers the state's publicly funded health care programs such as Medical Assistance and pays more than one million fee-for-service health care claims annually. DHS reports that:
    - The Department is receiving more electronic, automated claims and fewer needing manual review;
    - As a result of greater automation and streamlining, DHS was able to reduce its staff for claims processing from 41 to 16 persons, and to reallocate the 25 staff that previously worked in claims to new, higher priorities. In addition, greater claims processing automation allowed DHS to:
        - discontinue a software maintenance contract ($35,000 annually);
        - discontinue a post office box for paper claims ($9,000 annually);
        - reduce postage and electronic storage costs.[xvi]
- A national property-casualty insurer, State Farm, found that:
    - Electronic bill processing can be accomplished at a lower cost than paper processing;
    - If the transactions contain correct and complete data, including the property/casualty claim number, it is possible to reduce manual processing and costs;
    - Valid electronic bills contain more information than paper bills, and claims processing systems can better determine if bills meet requirements;
    - Electronic bills that do not meet the requirements can be identified and an electronic rejection transaction returned.[xvii]
- Other providers and payers have reported that reductions in health care administrative burdens will permit reallocation of critical information technology and operational resources to other high priority uses, including improving the flow of clinical health care data, where even greater savings and improvements in patient care are anticipated long term.

## b. Growing national recognition

*Minnesota's administrative streamlining accomplishments are receiving national recognition. For example:*

*i. CHCPI will represent MDH as a "state government representative" to the national Committee on Operating Rules for Information Exchange (CORE) Transition Committee*

The National Committee on Vital and Health Statistics (NCVHS) is a formal advisory body to the Secretary of HHS. It recently recommended that a national organization, the Committee on Operating Rules for Information Exchange (CORE) of the Council for Affordable Quality Health Care (CAQH), author Operating Rules required as part of PPACA, Section 1104.

In testimony before NCVHS, CORE cited Minnesota's administrative streamlining initiative and announced that it had selected Minnesota, along with a representative of the National Governor's Association (NGA), to represent state government interests nationally on a CORE transition committee. The committee will provide recommendations regarding CORE governance and funding, consistent with desires for fostering broader involvement in the CORE process. The Center has been selected to represent the Minnesota Department of Health (MDH) on the CORE transition committee.

*ii. Oregon's Administrative Simplification Work Group recommended that the state adopt the "Minnesota approach to standardization and automation"*

The 2009 Oregon Legislative Assembly directed the Office for Oregon Health Policy and Research (OHPR) to bring together a work group to recommend uniform standards for insurers for several administrative transactions. The charge was subsequently expanded to include development of a broad strategy for administrative simplification, specifying the appropriate role for the state, and estimating the potential for cost savings. The OHCR staffed a specially appointed "Administrative Simplification Work Group" to make recommendations. In 2009 and 2010 CHCPI provided information and participated in discussions with the Work Group and staff regarding Minnesota's initiative.

The Work Group issued its final report in June 2010. Its primary recommendation was that "Oregon should adopt the Minnesota approach to standardization and automation."[xviii] Oregon is now developing a series of single, uniform companion guides similar to Minnesota's. CHCPI continues to serve as a resource and to provide information and examples to the Oregon program as questions or needs arise.

Coordinating administrative simplification efforts with other states such as Oregon is important to prevent duplication of efforts, to reduce potential differences or gaps among states, and to effectively respond to national administrative simplification initiatives and requirements. In addition to working with Oregon, the Center has contacted other states to compare programs and to seek broader potential collaborations. In particular, during 2010 the Center began exchanging information regarding Minnesota's goals and activities with the State of Washington, which is

implementing a series of EDI-oriented best practices and undertaking other administrative streamlining activities.

*iii. CHCPI worked closely with the Minnesota Department of Labor and Industry (DLI) and national organizations to obtain new data codes for improved data reporting for workers' compensation medical billing nationwide*

While federal HIPAA administrative and code sets regulations do not apply to workers' compensation medical billings, Minnesota's requirements do. As a precondition for payment, and/or to satisfy other administrative or legal requirements, states often require certain "jurisdictional information" be included as part of workers' compensation transactions. However, reporting this information in the current context of standard, electronic data exchange was challenging for two reasons:

- First, electronic business transactions are communicated using certain established standard numeric or alpha-numeric codes as a shorthand for more detailed information. The available codes did not meet the workers' compensation jurisdictional reporting needs.
- Second, changing or adding codes also required the approval of a federally designated national standards development organization, known in this case as the American Standards Committee (ASC) X12. Obtaining the new codes required a strong business case and sufficient support for changes at the national level.

CHCPI worked with DLI, which oversees the state's workers' compensation system, and the AUC, to develop appropriate new data codes to facilitate EDI-based state jurisdictional reporting as part of worker's compensation medical claims submission and processing. As this was not uniquely a Minnesota need, the collaboration quickly expanded to a national level, including coordination with:

- the International Association of Industrial Accident Boards and Commissions (IAIABC), an association of government agencies that administer and regulate their jurisdiction's workers' compensation acts;
- the state of Texas, which is implementing an e-billing initiative for workers' compensation medical claims; and,
- the ASC X12 Health Care Claim Payment Work Group and other X12 members.

In the fall of 2010, this broad-based effort was successful in obtaining several new and revised codes from ASC X12 to facilitate EDI-based workers' compensation transactions with the needed jurisdictional reporting.

## c. Minnesota is well positioned to constructively contribute to and benefit from Section 1104 of PPACA and other federal initiatives

Because operating rules and other requirements of PPACA, Section 1104 have not yet been published, the full implications and impacts of Section 1104 for Minnesota and the industry are unclear at this time. States and the industry will need to monitor and participate to the extent possible in the development of the rules. They must also anticipate planning for and

implementing several sets of major federal regulations, often with little or no precedent, in a short timeframe over the next few years.

Despite the inherent uncertainty of emerging federal regulations and the challenges of implementing any changes, Minnesota's experience, collaborations, and working relationships provide opportunities to effectively contribute to and benefit from the federal regulations. For example:

- Minnesota has demonstrated that significant administrative simplification and rulemaking can be accomplished with the close involvement of the industry in a short time. This experience serves several practical purposes, from demonstrating a concrete example for achieving substantial change quickly, to preparing the state for any changes that may be needed under PPACA rules;
- Minnesota's recognition nationally provide it the credibility and standing to contribute effectively to many levels of discussions and recommendations as part of the PPACA rulemaking process over the next five years. CHCPI assisted the AUC in 2010 to develop and submit comments and recommendations to NCVHS regarding a number of PPACA provisions. The AUC is well situated to provide additional constructive comments and ideas to help shape, refine, and implement PPACA rules;
- The Center and the AUC are continually seeking broader collaboration, participation, and working relationships with other states and national organizations. CHCPI is a member of several relevant national organizations and, as discussed earlier, was recently asked to serve as one of two state government representatives to the CORE Transition Committee. CORE was recommended by NCVHS to author the first set of PPACA operating rules;
- CHCPI, in collaboration with the AUC, has taken an active role in tracking further federal rulemaking for PPACA, and in increasing awareness and familiarity with the PPACA timelines and process.

## III. CONCLUSION

In 2010, the Center continued to lead a first-in-the-nation rulemaking initiative for reducing costs and burdens associated with the exchange of health care business transactions throughout Minnesota's health care system. It provided significant staffing and other support to a large, voluntary stakeholder advisory group, the Minnesota Administrative Uniformity Committee (AUC), resulting in the promulgation or adoption of 20 sets of rules for greater uniformity and automation of administrative transactions, as well as recommendations to NCVHS and CMS regarding planned federal administrative simplification.

As a result of Minnesota's efforts during this period:

- Early indicators of system-wide efficiencies and cost-reductions from greater use of EDI-based health care business transactions are becoming more apparent;
- Minnesota is garnering national recognition for its efforts; and

- Minnesota is well-positioned to constructively influence and benefit from federal administrative simplification as part of federal health reform and other federal regulations.

In 2011, CHCPI will continue to work closely with the AUC to advance Minnesota's automation of health care administrative transactions, while also serving as a liaison and resource for additional administrative simplification and health reforms at the national level, and as a potential resource for other Minnesota health care reforms.

## Appendix 1
## Summary Overview of Minnesota Health Care Administrative Simplification Pursuant to Minnesota Statutes, section 62J.536

Overview and rationale

Health care has lagged far behind the financial, transportation, and other sectors of the economy in its use of efficient, effective, standard electronic exchanges of routine business transactions. The result is continued use of outdated paper and nonstandard electronic formats that are much less efficient, much more burdensome, and much more costly to the health care system.

For example, studies have reported that the average cost of processing paper health care claims (billings) was approximately double that of electronic billings, resulting in additional expenses of $0.60 to $0.73 per claim.[xix] When paper and nonstandard data exchanges are incomplete, inaccurate, or less timely, costs and delays are often compounded. A 2006 report estimated the costs for just follow-up telephone calls between Minnesota health care providers and payers to resolve questions related to patient eligibility for insurance coverage, benefits, and health care claims at between $15.5 and $21.8 million annually.[xx]

Because routine administrative transactions such as checking patient eligibility for benefits, submitting bills for services, or making payments to providers occur millions of times each year, even small inefficiencies add up to be significant costs and drags on health system productivity.

As described below, CHCPI is playing an important role in implementing requirements that administrative transactions be exchanged electronically, using a standard data content and format, to reduce overall administrative costs in Minnesota's health care system by an estimated $40 - $60 million per year.[xxi] In addition, achieving more standard, electronic exchanges of health care administrative transactions is important to meeting other goals for health care performance measurement and improved patient care.

In late 2006 the CHCPI responded to interests on the part of Governor Pawlenty's Health Cabinet to explore opportunities for rapidly aligning efforts to streamline and simplify routine health care administrative transactions. In December 2006, the Center planned and staffed a site visit to a promising example of alignment for health care administrative simplification in Utah, known as the Utah Health Information Network (UHIN). Minnesota's site visit delegation included nearly twenty state and private sector representatives, which met with a similar large contingent from UHIN for two days of discussion and information exchange.

The site visit led to broader discussions and momentum for changes in Minnesota to accelerate health care administrative simplification and standardization efforts. That interest culminated in the 2007 legislative session with passage of first-in-the-nation Minnesota Statutes, section 62J. 536, requiring that all health care providers and group purchasers (payers) exchange three types of common health care business transactions electronically, using a single, uniform data content

and format, effective 2009. The statute effectively addresses three root causes of unnecessary health care administrative costs and burdens as presented below.

### Three Key Challenges Addressed by Minnesota's Health Care Administrative Simplification Policy Framework

**1. Many health care business transactions are still exchanged on paper.**
Many health care transactions are still exchanged on paper, which national studies have shown to be about twice as expensive to process as electronic transactions.

- ***Solution:*** Minnesota requires that three high volume, important health care business transactions – eligibility verification; claims; payment remittance advices -- be exchanged electronically.

**1. A proliferation of "companion guides" to federal HIPAA transaction standards has resulted in variable, non-standard, more costly transactions.**

Current Federal HIPAA standards for the electronic exchange of health care business transactions are often not sufficiently detailed to be used independently of other instructions or specifications known as "companion guides". Many payers have issued their own companion guides with requirements for data exchange that supplement the HIPAA standards. Requiring many different ways of sending the same business transaction (e.g., billings or "claims") to different recipients (payers) creates unnecessary administrative burdens and costs.

- ***Solution:*** Minnesota requires a single, uniform companion guide to be used by all providers and all payers (except Medicare) for the exchange of eligibility verification, claims, and payment remittance advices. The three transactions chosen for the single companion guides and electronic exchange represent:
  - Key transactions within the health care business cycle;
  - Common, high volume, high value transactions;
  - Potential for savings, especially with improved eligibility information;
  - Recognition of industry and federal direction – for example, claims were being widely exchanged electronically and would be important to include.

**2. Many payers are not covered by federal HIPAA data exchange requirements.**

Federal HIPAA health care transactions and code sets rules do not apply to workers' compensation, property-casualty, and auto carriers. As a result, these payers have not been required to follow federal HIPAA rules for the electronic exchange of business transactions. Consequently, many transactions with these payers are often now conducted on paper or using nonstandard exchanges that are less efficient and more costly.

- ***Solution:*** Minnesota's requirements for the standard, electronic exchange of claims and payment remittances apply to non-HIPAA covered payers.

Minnesota Statutes, section 62J.536 rulemaking timelines and process

*a) Rules Timeline*

Minnesota Statutes, section 62J.536 further requires that the Minnesota Department of Health (MDH) adopt rules for the data content and format standards to be used in the exchange of the administrative transactions. The rules are to be promulgated at least one year in advance of the dates that they take the effect of law, as shown in the following table. The timeline below shows key dates for two versions of the rules, reflecting that the initial versions, v. 4010 and v. 5.1, have been superseded by v. 5010 and v. D.0, to be compliant with federal HIPPA regulations enacted in 2009.

| Health care transaction | Rule Promulgation Deadline | Rule Implementation (Rule has the force of law) |
|---|---|---|
| **Eligibility Inquiry and Response** (270/271) | | |
| ▪ v. 4010 | January 15, 2008 | January 15, 2009 |
| ▪ v. 5010 | December 31, 2010 | January 1, 2012 |
| **Claims – v. 4010** | | |
| ▪ Professional (837P)<br>▪ Institutional (837I)<br>▪ Dental (837D)<br>Pharmacy claims – v. 5.1 | July 15, 2008 | July 15, 2009 |
| **Claims – v. 5010** | | |
| ▪ Professional (837P)<br>▪ Institutional (837I)<br>▪ Dental (837D)<br>Pharmacy claims – v. D.0 | December 31, 2010 | January 1, 2012 |
| **Payment remittance advice (835)** | | |
| ▪ v. 4010 | December 15, 2008 | December 15, 2009 |
| ▪ v. 5010 | December 31, 2010 | January 1, 2012 |
| **Acknowledgments – v. 5010**<br>▪ TA1<br>▪ 999<br>▪ 277CA | December 31, 2010 | January 1, 2012 |

*b) Minnesota's rules are based on federal HIPAA regulations and Medicare, in consultation with large stakeholder group, the Minnesota Administrative Uniformity Committee (AUC)*

Minnesota Statutes, section 62J.536 specifies that the rules be based on federal Health Insurance Portability and Accountability Act (HIPAA)[xxii] transactions and code sets requirements and the federal Medicare program, with modifications the Commissioner of Health finds appropriate after consulting with the Minnesota Administrative Uniformity Committee (AUC). The AUC is a broad-based, voluntary group representing Minnesota's public and private health care payers, hospitals, health care providers and state agencies. It has served since 1992 to develop agreement among payers and providers on standardized administrative processes. The AUC acts as a consulting body to various public and private entities, but does not formally report to any organization and is not a statutory committee. It meets as a large committee of the whole, as well as through numerous work groups and Technical Advisory Groups (TAGs). The work groups and TAGs reflect particular areas of expertise and divisions of labor with respect to different types of health care administrative transactions and processes.

*c) Rule development and administration provides for systematic rule updates*

In addition to the statutory rule development and implementation deadlines above, CHCPI and the AUC developed an additional process to provide for a review of the rules six months after their adoption, but six months before they take the effect of law, for any possible clarifications, technical updates, or changes that may be indicated with preliminary experience and testing of the rules. The Center and the AUC also planned for annual in-depth reviews and maintenance of the rules, as well as any revisions that may be needed to conform with changes to federal HIPAA transactions and code set regulations.

## Appendix 2
## Section 1104 of the Patient Protection and Affordable Care Act (PPACA)

Section 1104 of the Patient Protection and Affordable Care Act (PPACA), enacted in March 2010, brings about the most sweeping national health care administrative simplification in a decade. The law requires the Secretary of the US Department of Health and Human Services (HHS) to develop and implement a variety of rules and standards over the next five years to standardize and automate a number of important health care business transactions.

The tables and chart below show the time lines for completing the PPACA rules and other related PPACA milestones. In addition, it also summarizes other important state and federal health care EDI initiatives. Most notably, the illustrations below summarize efforts to accelerate the flow of standard, electronic patient clinical data through adoption of incentives for "meaningful use" of Electronic Health Records (EHRs). These incentives were part of federal legislation and rules enacted in 2009-2010 under the Health Information Technology for Economic and Clinical Health (HITECH) Act as part the American Reinvestment and Recovery Act (ARRA). The chart also includes Minnesota-specific requirements for implementation of e-prescribing and interoperable EHRs.

At present, initiatives to advance the exchange of clinical health care data are generally being undertaken separately from improvements in administrative transactions. However, the two efforts are complementary, and many anticipate they will converge over time. In addition, efforts to promote the exchange of standard, electronic patient clinical data may draw upon many of the same resources and much of the same expertise as administrative simplification. Each type of activity thus needs to be considered when planning for the other.

CHCPI is closely monitoring the development of federal operating rules and new HIPAA standards as well as developments in the clinical data exchange arena. It anticipates maintaining much of its current focus on administrative simplification in 2011 and playing an important role in aiding Minnesota's implementation and compliance with the PPACA to meet the deadlines below.

### Table 1. Summary of PPACA Operating Rules Time Lines

Table 1 lists common health care business transactions that will become more uniform under federal reform. It also lists the dates by which certain federal rulemaking milestones must be reached, including dates by which health plans must be able to certify that they are compliant with the operating rules.

| Category/Type of Business Transaction | PPACA Operating Rules Adoption | PPACA Operating Rules Effective Dates | Health Plan Certification and Compliance Dates |
|---|---|---|---|
| ▪ Eligibility | 7/1/2011 | 1/1/2013 | 12/31/2013 |
| ▪ Claim Status | 7/1/2011 | 1/1/2013 | 12/31/2013 |

| Category/Type of Business Transaction | PPACA Operating Rules Adoption | PPACA Operating Rules Effective Dates | Health Plan Certification and Compliance Dates |
|---|---|---|---|
| ▪ Electronic Funds Transfer (EFT) | 7/1/2012 | 1/1/2014 | 12/31/2013 |
| ▪ Remittance Advice | 7/1/2012 | 1/1/2014 | 12/31/2013 |
| ▪ Claims Attachments | 1/1/2014 | 1/1/2016 | 12/31/2015 |
| ▪ Claims | 7/1/2014 | 1/1/2016 | 12/31/2015 |
| ▪ Enrollment/Disenrollment | 7/1/2014 | 1/1/2016 | 12/31/2015 |
| ▪ Premium Payment | 7/1/2014 | 1/1/2016 | 12/31/2015 |
| ▪ Referral Certification/Authorization | 7/1/2014 | 1/1/2016 | 12/31/2015 |
| ▪ Health Plan Identifier | See below | | |

**Table 2. Summary Time Lines for New HIPAA Standards Under PPACA**

Table 2 summarizes implementation deadlines for new HIPAA transaction standards over the next five years. (Note: At this time both HIPAA standards and complementary operating rules are needed to achieve the greatest standardization and automation of health care business activity. The standards and operating rules currently do not exist for three transactions, Electronic Funds Transfer (EFT), Claims Attachments, and Health Plan Identifier. For this reason, these three transactions appear in both Table 1 and Table 2).

| Category/Transaction | New HIPAA Standards Adoption Dates | New HIPAA Standards Effective Dates |
|---|---|---|
| ▪ Electronic Funds Transfer | 1/1/2012 | 1/1/2014 |
| ▪ Claims Attachments | 1/1/2014 | 1/1/2016 |
| ▪ Health Plan Identifier | N/A | 1/1/2012 |

**Table 3. Summary of Additional Federal and State Health Information Technology (HIT) Regulation Time Lines**

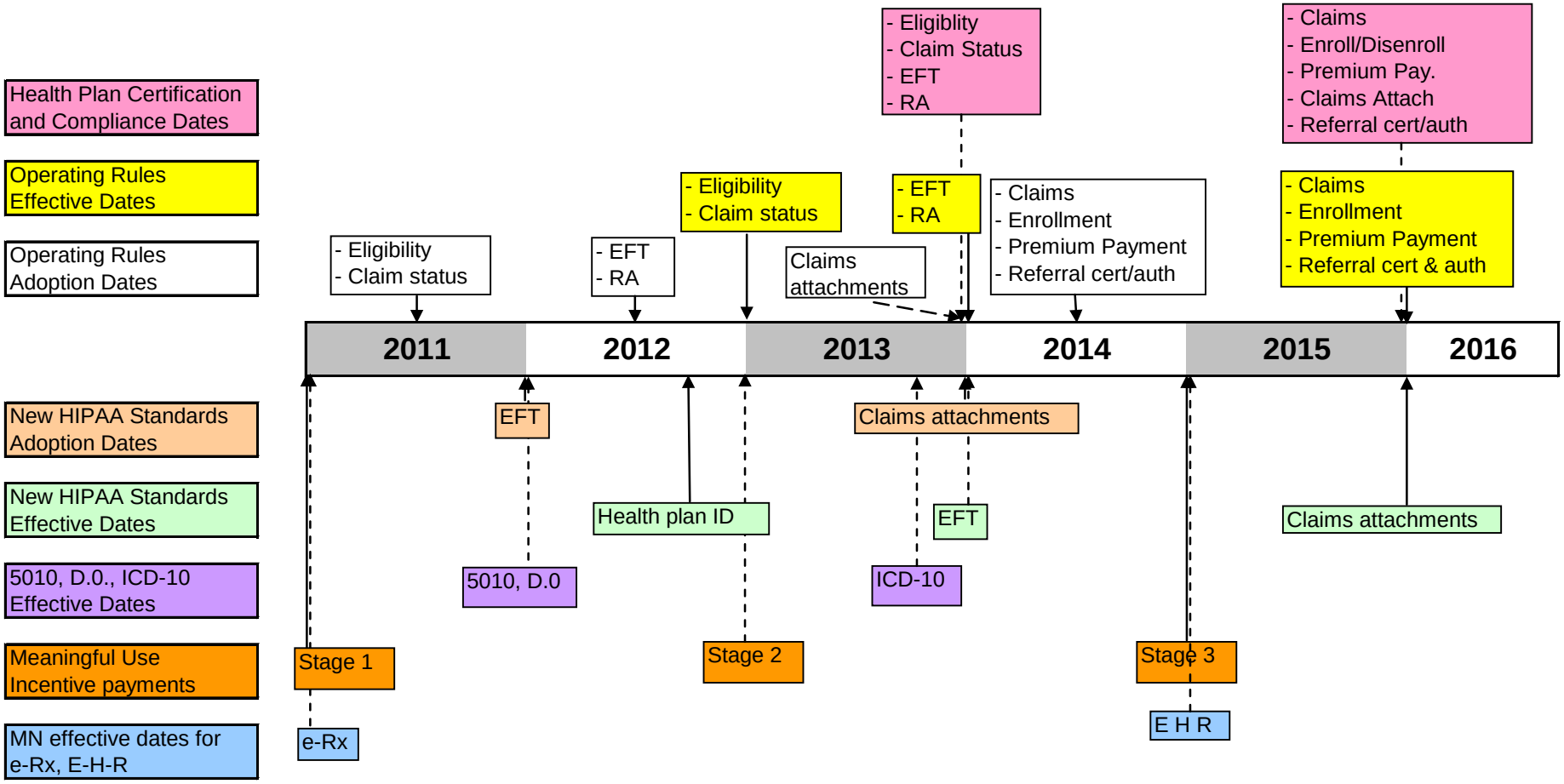
Table 3 shows additional important health information technology (HIT) deadlines in federal and state regulations pertaining to clinical data exchange. The Center does not have a direct role in these latter activities at this time, but as noted above, clinical data exchange requirements should be considered for planning purposes, and because they are likely to converge to a greater degree with administrative simplification efforts in the future.

| Category | Dates |
|---|---|
| Version 5010 of current HIPAA transaction and code sets rules | 1/1/2012 |
| ICD-10 (International Classification of Diseases, 10th revision) | 10/1/2013 |

| Category | Dates |
|---|---|
| Incentives for Meaningful Use of Electronic Health Records (EHRs) | Stage 1 – 2011<br>Stage 2 – 2013<br>Stage 3 – 2014 |
| Minnesota requirements:<br>▪ e-Prescribing<br>▪ Adoption of interoperable EHR | <br>1/1/2011<br>1/1/2015 |

**Chart 1. Preliminary Working Draft: Section 1104, Administrative Simplification, Patient Protection and Affordable Care Act (PPACA) and other selected federal/state health care data exchange initiatives**[xxiii]

Chart 1 displays the information in the three tables described above in a single time line.



## Endnotes

[i] Preliminary unpublished estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), February 2011. The estimate was developed using data from other state and national studies regarding savings of standard, electronic health care business transactions, applied to preliminary data and assumptions for Minnesota regarding rates of standard, electronic health care transactions. National source data included:

> Milliman Technology and Operations Solutions. (Revised January 2006). Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from http://www.ushealthcareindex.com/resources/Milliman_EDI_Benefits.pdf
>
> American Medical Association Practice Management Center. (June 22, 2009). Standardization of the Claims Process: Administrative Simplification White Paper. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-wp.pdf
>
> American Medical Association Practice Management Center. (2008). Follow That Claim: Claim Submission, Processing, Adjudication, and Payment. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/368/follow-that-claim.pdf
>
> Office for Oregon Health Policy and Research. (June 2010). Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group. Page 17. Retrieved from http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/AdminSimplification/Docs/FinalReport_AdminSimp_6.3.10.pdf?ga=t

[ii] Minnesota Department of Health, Division of Health Policy, Health Economics Program. (2011). Minnesota Health Care Spending by Source of Funds, 2008. Minnesota Health Care Markets Chartbook, Section 1: Minnesota Health Care Spending and Cost Drivers. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/chartbook/index.html

[iii] Economic Research, Federal Reserve Bank of St. Louis. (2011). Real Total Gross Domestic Product by State for Minnesota (MNRGSP). Retrieved from http://research.stlouisfed.org/fred2/series/MNRGSP

[iv] United States Department of Agriculture, Economic Research Service. (2011). Farm Financial Indicators: Farm Income and Value Added Data. Data Sets. State Fact Sheets: Minnesota. Final Minnesota agricultural sector output for 2008 equaled $18.3 billion. Retrieved from http://www.ers.usda.gov/StateFacts/MN.htm

State of Minnesota, Explore Minnesota. (2011). Tourism and Minnesota's Economic Recovery. Retrieved from http://industry.exploreminnesota.com/wp-content/uploads/2011/01/Tourism_and_Economy_2011_edition_2-7-11.pdf

[v] Sources:

> Personal communications, Minnesota Department of Human Services (DHS) and Minnesota Department of Management and Budget (MMB), 2011. DHS reported projected FY2011 average enrollment in Medical Assistance Basic Care and MinnesotaCare at 824,000, with total payments of $5.1 billion. MMB reported calendar 2010 enrollment of 118,000 and over $.581 billion annual costs for the health insurance component of the State Employee Group Insurance Program (SEGIP).

[vi] See for example several reports and studies including:

> Institute of Medicine, Committee on Health Care in America. (2001). Crossing the Quality Chasm: A New Health System for the 21st Century. Retrieved from http://www.nap.edu/openbook.php?isbn=0309072808

Minnesota Citizens Forum on Health Care Costs. (2004). Report of the Minnesota Citizens Forum on Health Care Costs. Retrieved from http://www.minnesotahealthinfo.org/other/citizensforum.pdf

Health Care Transformation Task Force. (2008). Recommendations Submitted to Governor Tim Pawlenty and the Minnesota State Legislature. Retrieved from http://www.health.state.mn.us/divs/hpsc/hep/transform/ttfreportfinal.pdf

[vii] Milliman Technology and Operations Solutions. (2006) Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from http://www.ushealthcareindex.com/resources/Milliman_EDI_Benefits.pdf

[viii] Minnesota Office of the Revisor of Statutes. (2010). 2010 Minnesota Statutes. 62J.63 Center for Health Care Purchasing Improvement. Retrieved from https://www.revisor.mn.gov/statutes/?id=62J.63

[ix] Centers for Medicare and Medicaid Services (CMS). HCPCS – General Information: Overview, HCPCS Background Information. Retrieved from http://www.cms.gov/MedHCPCSGenInfo/

[x] Personal communication, Minnesota Council of Health Plans 2010.

[xi] Milliman Technology and Operations Solutions. (2006) Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from http://www.ushealthcareindex.com/resources/Milliman_EDI_Benefits.pdf

[xii] Ibid.

[xiii] Preliminary unpublished estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), February 2011. (See endnote i above)

[xiv] Personal communication, Minnesota Council of Health Plans 2010.

[xv] Preliminary unpublished estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), January, 2010. Estimate was developed using data from the following source, applied to Minnesota's increased rate of electronic claims. Data Source: Milliman Technology and Operations Solutions. (2006) Electronic Transaction Savings Opportunities for Physician Practices. Retrieved from http://www.ushealthcareindex.com/resources/Milliman_EDI_Benefits.pdf

[xvi] Personal communication. Minnesota Department of Human Services. October, 2010.

[xvii] Personal communication. State Farm Insurance. December, 2010.

[xviii] Office for Oregon Health Policy and Research. (June 2010). Oregon Administrative Simplification Strategy and Recommendations: Final Report of the Administrative Simplification Work Group. Retrieved from http://www.oregon.gov/OHA/OHPR/HEALTHREFORM/AdminSimplification/Docs/FinalReport_AdminSimp_6.3.10.pdf?ga=t

[xix] Sources:

Center for Policy and Research, America's Health Insurance Plans. (2006). An Updated Survey of Health Care Claims Receipt and Processing Times. Retrieved from http://www.ahipresearch.org/pdfs/PromptPayFinalDraft.pdf

American Medical Association Practice Management Center. (June 22, 2009). Standardization of the Claims Process: Administrative Simplification White Paper. Retrieved from http://www.ama-assn.org/ama1/pub/upload/mm/368/admin-simp-wp.pdf

[xx] Minnesota Administrative Simplification Work Group. (2006) 2006 Administrative Simplification Project – Project Documentation. (working paper).

[xxi] Preliminary unpublished estimate, Minnesota Department of Health, Center for Health Care Purchasing Improvement (CHCPI), February 2011. (See endnote I above)

[xxii] The federal Health Insurance Portability and Accountability Act of 1996 (HIPAA) provides for: maintenance of health insurance coverage after leaving an employer; and standards for health-care-related electronic transactions. While HIPAA provided important standardization of electronic health care transactions, it did not address all standardization issues. Requirements of Minnesota Statues, section 62J.536 further harmonize and clarify HIPAA standards, for group purchasers and health care providers to exchange health care administrative transactions electronically.

[xxiii] Minnesota Department of Health, Division of Health Policy, Center for Health Care Purchasing Improvement. (2011). Chart 1 was first presented at the regular monthly meeting of the Minnesota Administrative Uniformity Committee, April 12, 2010.