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Management Analysis & Development

Report to the 2012 Legislature

Regulatory simplification and reduction of provider reporting and data submission requirements

Laws 2011, first special session, Chapter 9, Article 6, Section 90

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Minnesota Management & Budget, 203 Administration Building, 50 Sherburne Avenue, St. Paul, MN 55155
Telephone: 651-259-3813 • *Fax:* 651-797-1311 • *TTY:* 800-627-3529 • www.mad.state.mn.us

Project team
Ralph Brown
Renee Raduenz

Division director
Bill Clausen

Division assistant director
Kristin Batson

Contact information
Voice: 651-259-3800
E-mail: manalysis@state.mn.us
Fax: 651-797-1311
Website: www.mad.state.mn.us
Address:
203 Administration Building
50 Sherburne Avenue
St. Paul, Minnesota 55155

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Acknowledgements

Although Minnesota Management & Budget coordinated the development of this report, it must be acknowledged that about 60 people outside of the department did most of the actual work. About half of these people were staff members of the departments of Health, Human Services and Commerce. They searched state reports and data submissions, looking for opportunities for potential report eliminations, reductions and other simplifications. The others were staff members of stakeholders – health plans, health care providers, and their state associations – who also searched for opportunities for report simplifications. The interaction between the agency staff and the stakeholder staff was invaluable, and resulted in the enclosed recommendations. Among the stakeholder organizations represented were: Aging Services of Minnesota; Allina Hospitals and Clinics; Blue Cross, Blue Shield, Blue Plus; Care Providers of Minnesota; Cirdan Health Systems and Consulting, representing County-Based Purchasers; HealthPartners; Minnesota Council of Health Plans; Minnesota Hospital Association; Preferred One; PrimeWest Health; Rice Memorial Hospital, Willmar; and UCare.

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Executive summary

I. Background

A. Introduction. In the 2011 special session, the Minnesota Legislature authorized a work group to develop recommendations that would "eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittal requirements for health care providers or group purchasers related to health care costs, quality, utilization, access or patient encounters or related to provider or group purchaser, monitoring, finances, and regulation." (Laws 2011, 1st Sp. Sess., Ch. 9, a. 6, s. 90). The work group was convened and facilitated by Minnesota Management & Budget, and included representatives from the departments of Health (MDH), Human Services (DHS) and Commerce. The work group was directed to develop a plan for regulatory simplification and report reduction activities in seven specified areas. In addition, the agencies were directed to develop criteria to be used in determining whether to establish new reporting and data submission requirements. The criteria must take into account a specified set of standards as outlined in the legislation to support new reports and/or data submissions.

B. Project scope. The project scope adhered to the legislative mandate. The work group members compiled an inventory of reports and data submissions required by the three agencies in the categories specified by the legislation. The inventory was modified during the process to ensure that it covered the concerns of stakeholders responsible for submitting the reports. Ultimately 80 reports were included in the inventory. (See Attachment C.) The project was limited to identifying "redundant, unnecessary and obsolete" reporting within the context of current state policy and practice.

C. Work group process. The project process included a series of interviews with key stakeholder leaders representing statewide associations of health plans and health care providers and related organizations. Agency staff developed and discussed the inventory of reports. Agency staff identified five major categories and placed the reports within the appropriate category, with some reports in more than one category. These category lists were provided to stakeholders in preparation for five meetings in which stakeholders and agency staff discussed the rationale for reports and suggestions for simplification. Agency staff met again after the stakeholder sessions to discuss the concerns and suggestions presented by the stakeholders. The process resulted in numerous outcomes; most can be acted upon administratively during the next year or two. Due to the complexity of some reports, some suggested changes need further consideration beyond this project. The recommendations in this report have the support of the respective agencies. Altogether, 26 short-term recommendations affect 30 of the examined reports; long-term recommendations would affect others, particularly those involving encounter data.

D. Simplification context. During this project it became clear that stakeholder suggestions and agency report streamlining actions are not new: many examples

were noted of reports that have been eliminated or simplified in the past. Some changes have been part of a periodic review process and others have been incidental. Many changes have not been stand-alone, but components of a large scale improvement initiative. There are a number of areas today where stakeholders and agency staff periodically review reports and data submission for opportunities to simplify.

E. **Suggestions not recommended.** Not all suggested changes have been recommended: some continue to be under consideration, and some were not found to be workable under current conditions. Other suggestions were outside the project scope, including broad policy changes or involving agencies beyond those specified in statute; and others were prohibited by federal requirements. In addition to suggestions still under consideration, other changes may become possible as the health care environment changes, particularly as health care reform and other federal standards and guidelines evolve.

II. Short-term recommendations

A. **Eliminate or merge certain reports.** Nine current reports or data submissions have been recommended for elimination. The relevant state agencies intend to move forward on these recommendations.

B. **Reduce or simplify certain reports.** Six current reports or data submissions have been recommended for reduction, modification, merger or other simplification. The relevant state agencies intend to move forward on these recommendations.

C. **Complete the conversations.** Eleven current reports or sets of related reports have been identified for potential simplification but require additional review. The relevant state agencies intend to continue examination of these change efforts. In a number of areas, high-level agreement between stakeholders and agencies has been reached on some recommendations, and agencies have agreed to continue the effort to make the change operational during the next couple of years. Long-term recommendations are covered in the following section.

D. **Create purpose statements.** Frequently stakeholders suggested elimination of reports that appear to serve no useful purpose. In fact, the reports continue to serve a purpose, but the purpose is unclear or unknown to stakeholders. Agencies have accepted a stakeholder suggestion to expand the use of purpose statements added to data collection efforts, along with dates to indicate when the purpose statements were established. Stakeholders have asked that collected data not be prescribed or limited by the purpose statement, so that agencies might use the data to reduce other reports collecting the same or similar data.

III. Long term recommendations

A. **Major change initiatives.** Beyond the specifics in the short-term recommendations, the project has examined the potential for major, significant changes that can transform reporting and information sharing between

stakeholders and public agencies. In the future, improvement may come from realigning reporting in conjunction with the national and state-level health care market, standard-setting and reform changes now in development. The emergence of accountable care organizations (ACOs), health care homes, and changes in federal law can be opportunities to rethink and reorder data needs. This can combine with better use of existing data sources including encounter data and other reports and surveys. Major health initiatives are multi-year initiatives and many variables are unknown. However, many of the short-term recommendations included here signify initial steps to prepare agencies and stakeholders for larger-scale and longer-term reporting improvements in the next few years. A large scale change is the potential for expanded use of encounter data; this opportunity is described in the next section.

B. Encounter data. Stakeholders have noted that while they recognize the value of encounter data and support its continued collection, having dual streams of public program encounter (claims) data collected by MDH and DHS creates opportunities for reducing the reporting burden. Both agencies have committed to finding ways to ease that burden, in part by moving toward a single standard for reporting post-adjudicated medical claims data. This will provide an opportunity to establish new, consistent standards in data collection across agencies. It may not reduce the number of reports but could significantly ease the administrative burden on health plans required to submit data. The agencies have committed to invite managed care organizations to work with them to examine draft national standards now in development and provide feedback to the American National Standards Institute shortly after guidelines are released in early 2012.

C. New report criteria. The law establishing the work group called for criteria to be used in determining whether to establish new reporting and data submission requirements. It specifies the criteria must support new data submittal requirements only: 1) if required by a federal agency or state statute; 2) if needed for a state regulatory audit or corrective action plan; 3) if needed to monitor or protect public health; 4) if needed to manage the cost and quality of Minnesota's public health insurance programs; or 5) if a review and analysis by the commissioner of the relevant agency has documented the necessity, importance and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report. These specifics provide an effective set of criteria. Agencies have agreed that any new report must meet one of the five criteria. Agencies also agree they will first see whether the specific information sought is already reasonably available through another state or federal report. These criteria meet the legislative intent and address most of the concerns raised by stakeholders.

D. Continuing engagement. Agency staff members found value from the project work group. It was a chance to consider, with the help of stakeholders, ways to simplify and improve their own agency's reports and data submissions, and it also provided a forum to better understand the role and requirements of the other agencies. While some issues will be resolved within the next year, other issues

will need further consideration. In particular, issues will arise as health care undergoes change on the national level.

As noted earlier in this report, state agencies already conduct a number of periodic interactions with stakeholders involved with specific reports. The agencies have agreed to initiate an annual meeting regarding: 1) the potential state impact from national data developments; 2) each agency's anticipated data-related changes for the coming year; 3) the status of ongoing improvement efforts; and 4) new joint possibilities for report simplification. Prior to meeting, each agency needs to connect with stakeholders, providing them with ample opportunities to relate their concerns and suggestions regarding both current and anticipated reporting.

I. Background

A. Introduction

Minnesota state agencies collect data for a variety of reasons. Health care-related data is collected to comply with federal and state regulations, judicial obligations, or other state purposes. These include meeting regulatory requirements (for example, the Children's Health Insurance Program Reauthorization Act of 2009, a federal initiative to ensure dental access for children), the development of evidence-based health policy (for example, what is the effect on cost and services of expanding the state's hospital bed capacity), or the execution of required functions (for example, the calculation of disproportionate payments to Medicaid-serving hospitals). The basis for requiring health care providers or group purchasers to provide reports and data submissions to the State is primarily due to statutory compliance, both federal and state, but are also a result of contractual requirements that serve policy initiative and purposes.

Both the need for, and the requirements of, reports and data submissions can change over time. A question that has been continually raised by state agencies, health care providers and group purchasers alike is whether the processes and formats of reporting have changed correspondingly with the need.

In the 2011 special session, the Minnesota Legislature authorized a work group to develop recommendations that would "eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittal requirements for health care providers or group purchasers related to health care costs, quality, utilization, access or patient encounters or related to provider or group purchaser, monitoring, finances, and regulation." (Laws 2011, 1st Sp. Sess., Ch. 9, a. 6, s. 90.) Four state agencies – Minnesota Management & Budget as work group convener along with the departments of Health, Human Services and Commerce – were directed to develop a plan for regulatory simplification and report reduction activities in seven specified areas:

- Encounter data;
- Group purchaser provider network data;
- Financial reporting;
- Reporting and documentation requirements relating to member communications and marketing materials;
- State regulations and oversight of group purchasers;
- Requirements and procedures for denial, termination, or reduction of services and member appeals and grievances; and
- State performance improvement projects, requirements and procedures.

In addition, the agencies were directed to develop criteria to be used by the agencies in determining whether to establish new reporting and data submittal requirements. The criteria must support establishing new requirements only if:

- Required by a federal agency or state statute;
- Needed for a state regulatory audit or corrective action plan;
- Needed to monitor or protect public health;
- Needed to manage the cost and quality of Minnesota's public health insurance programs; or
- A review and analysis by the commissioner of the relevant agency documents the necessity, importance and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report.

The agencies also were given the option of proposing new reporting and data submission requirements to take effect on or after July 1, 2012, including an analysis of the extent to which requirements meet the above criteria.

B. Project scope

The scope of the project adhered to the statutory language. Agency staff compiled an initial draft inventory of reports and data submissions required by the designated agencies – the departments of Health, Human Services and Commerce – in the seven specified areas noted above. Ultimately, the inventory included 80 reports. (*The accompanying numbers in brackets refer to the inventory attachment.*)

For this report, stakeholders refers to the health plans and health care providers, as described in session law, who are directly responsible for providing reports and data submissions. Based on interaction with these stakeholders and discussions of their concerns, the inventory does not include reports that are required to be reported upon occurrence or that did not fall into any of the categories described in the legislation. For example, "incident reporting" such as infectious disease reports and adverse event reports were excluded, as they do not fall into any of the seven categories outlined in statute, and are only triggered when a particular event occurs rather than being required of all stakeholders on a regular basis. At the same time, however, stakeholders were informed that the inventory was only a starting point for conversation and that any report or data submission in the areas of legislative concern would be open for consideration for change. Stakeholders responded to that invitation; several of the reports recommended for simplification were added to the inventory at the request of stakeholders.

The project scope, as set forth in the statutory language, was limited to identifying "redundant, unnecessary and obsolete" reporting and data submissions. Some stakeholders proposed reporting reductions that would accompany, or necessitate, substantive change in a state policy. Examples outside of the scope included suggestions to change policy on how data is used, rather than how it is reported, and suggestions for reports primarily involving state agencies other than the three designated agencies. In the

following list of recommendations for action in the short-term, this report is limited to practical simplification changes that can be made within the context of current state policy and practice. The short-term recommendations in this report include no proposed policy changes. The long-term recommendations section does note that expanded use of encounter data does have policy implications.

C. Work group process

The project began with a series of interviews of key stakeholder leaders. Beginning in early October, the project team held interviews with 13 people selected by organizations representing statewide associations of health plans and health care providers and related organizations. Stakeholder leaders provided an overview of reporting requirements and their concerns. Along with specific recommendations for simplification and consolidation, stakeholders suggested methodologies for further and ongoing reviews of the data reporting process. At the same time, staff members from the departments of Health, Human Services and Commerce compiled their inventories, adjusted them based on initial stakeholder comments, and began internal reviews of reporting requirements.

The agency inventories were combined into a multi-agency master list of 80 reports. Because it was extensive, it was believed that conversation would be more meaningful if the list could be divided into "like" categories with meetings focused on similar materials. The master list was subdivided into five smaller lists organized along the lines of the statutory categories. (Some reports straddled the categorical lines and were placed in more than one of the smaller inventories.) The five smaller inventories were then shared with stakeholders, who were invited to attend any and all of five meetings – one meeting for each of the categorical inventories. The inventories have since been merged again and are appended to this report.

The purpose of the meetings was to allow stakeholders to offer specific recommendations to simplify reports and data submissions in any manner, including elimination, reduction, streamlining, merger or modification of data submission timing or method, as well as to participate in a dialogue with state agencies. All of the meetings were conducted in an informal, conversational approach, with interaction among stakeholders and agency staff. Agency staff did not make any decisions at the meetings, but they were able to answer questions, explain why data was needed, and gather a better understanding of stakeholder rationale for proposed changes.

In addition to recommending reporting and data submission changes, stakeholders discussed ways to address simplification in the future and suggested opportunities for improvement in conjunction with anticipated changes on the federal level. Stakeholders were assured that the inventories were a starting point for conversation and that other reports could be considered as well; several stakeholders did recommend changes to reports not on any initial inventory. Stakeholders were again reminded that their opportunity for suggestions was not limited to the meetings, but that recommendations could be submitted at any time. A number of stakeholders did follow up with emails and other documentation.

Following the meetings, agency staff gathered to review all suggestions. The statutory language requires that recommendations come from the commissioners of the respective agencies, and staff members worked to determine which recommendations could move forward at this time, and which recommendations would need further examination. Those determinations are included in this report.

A number of stakeholders who helped identify reports that are candidates for simplification have indicated they are continuing their work and will bring forward additional suggestions past the deadline for this report. The recommendations in this report also address how to continue report simplification on an on-going basis.

Altogether, 26 short-term recommendations in this report affect 30 of 80 examined reports; long-term recommendations could affect many others, particularly those involving encounter data. In addition, one short-term recommendation impacts all reports and a long-term recommendation impacts any new reports in the future.

D. Simplification context

Through the course of this project it became abundantly clear that both stakeholder suggestions and agency actions to simplify reporting and data submission requirements are not new. Many examples were noted of reports that have been eliminated or simplified in the past. Some changes have been made as part of a periodic review process; others have been incidental in nature, often triggered by a stakeholder suggestion. It was noted that simplification on a relatively large scale has tended to happen not as a stand-alone activity but as a component of a large scale improvement initiative. In particular, several stakeholders and agency staff noted that the transformation of data systems from paper-based to an electronic format prompted a significant amount of simplification.

Examples of reports that previously have been eliminated, reduced or simplified include: (*The accompanying numbers in brackets refer to the inventory attachment.*)

- The Managed Care Organization's (MCO's) Primary Care Network List (PCNL) is submitted to DHS for review and approval and is a document provided to potential enrollees who must select a MCO at initial and open enrollment. The list identifies primary care providers within the MCO's network within a defined service area. DHS has reduced this report from a quarterly submission to a semi-annual submission. [43]

- DHS requires MCOs to report notices to enrollees of denials, terminations and reductions (DTRs) for services and claims, and to report grievances and appeals data. This is considered onerous by some MCOs. However, this data is used to monitor MCO performance and compliance regarding the MCOs grievance system and enrollee access to care and due process. DHS has simplified and streamlined the data collection and reporting process by creating an online web-based application which allows MCOs to directly upload data. Online edits provide immediate feedback to the MCOs to ensure accuracy before accepting data. The timeframe for submission and validation of the data has been reduced

significantly and the process has improved the quality of the data. [56, 57, 58]

- Stakeholders have asked DHS to combine the Provider Directory and Primary Care Network List (PCNL). However, these documents serve different audiences. The PCNL specifically addresses potential enrollees by providing specific information on primary care providers that the enrollee will need to select as the enrollee's designated provider. The Provider Directory includes all of the MCO's providers, including specialists, and is provided to the enrollee when the enrollee has selected and enrolled in a specific MCO. To combine the PCNL and the Provider Directory would add significant mailing costs to counties and the State who are responsible for the mailing of the PCNLs at initial and open enrollment. DHS is interested in looking at ways to reduce the costs of producing and mailing enrollee materials such as the PCNL and the Provider Directory. Last year DHS was successful in negotiating with the Centers for Medicare and Medicaid Services (CMS) to allow some flexibility in how the MCO makes available the Provider Directory to enrollees. MCOs can now provide the directory electronically by posting it to the MCO's website, however the MCO must document the enrollee's choice to receive the directory electronically. This year DHS has included the PCNL and the Evidence of Coverage on the list of materials that can be accessed electronically, but still must require the MCO to document the enrollee's choice to access the information electronically per the requirement of CMS. DHS continues to work with CMS on simplifying the access to enrollee information and materials. Federal authority: 42 CFR 438.10. [42, 43]

- Prescription drug cost reports and provider financial and statistical reports, which were previously submitted annually to MDH, were eliminated during the 2011 legislative session. This proposal was part of the Governor's budget request.

- The MDH Changes in Participating Entities report monitors the continuing adequacy of a network and identifies the need for corrective action if a deficiency appears. It was recently reduced; it is required only for provider contract terminations; before, it also was required for additions. State authority: M.S. 62D.08, subd. 5.[6]

- In an earlier change (1996), MDH consolidated four separate reports required annually from hospitals into one, the Hospital Annual Report [18]. Through an annual collaborative review process, MDH and its partner in data collection, the Minnesota Hospital Association, eliminated collection of multiple data elements in approximately seven question domains.

Following are some examples of areas in which stakeholders and agency staff periodically review reports and data submission for opportunities to simplify:

- DHS contracts with MCOs on an annual basis to provide health care services to public program enrollees. During the negotiations, contract reporting requirements are explained and discussed with the MCOs and they are given opportunity to offer suggestions for changes to the requirements which often are agreed to between DHS and the MCO.

- MDH staff members consult annually with the Minnesota Hospital Association to incorporate edits into the Hospital Annual Report (HAR) dataset. Over time, this process has resulted in elimination of some data elements and substitution of sources of data to reduce the reporting burden. MDH also works with the data collection vendor, the Minnesota Hospital Association, and hospitals on education efforts around data quality improvements and the use of the data and definition of data elements.

- Stakeholders have numerous opportunities to participate in the MDH annual review process for the Statewide Quality Reporting and Measurement system, including:

  - Preliminary and final recommendations from the Department's contractor, developed by using a well-established community-driven work group process;
  - Public forum presentation of recommendations;
  - Measure development work groups comprised of providers, health plans, consumers and other relevant experts;
  - Multiple informal and formal public review and comment periods; and
  - The opportunity to submit recommendations directly to the Department.

  The annual review culminates in an administrative rule-making process. MDH leverages relationships with organizations that represent relevant stakeholders and actively solicits feedback throughout the review and rule-making processes. MDH gives significant weight to the comments received and routinely modifies the administrative rules to incorporate feedback. Reporting requirements are aligned with national efforts wherever possible in an effort to minimize burden on providers. MDH staff and its contractor also assist clinics, ambulatory surgical centers and hospitals with reporting requirements throughout the year.

- Commerce, as the state department responsible for the regulation of insurance, actively participates with other state insurance departments as part of the National Association of Insurance Commissioners (NAIC) activities, including the development of NAIC model reporting requirements. The process for review of the NAIC model reporting is an open process which provides for stakeholder feedback and discussion among states. Much of the reporting required by the Department of Commerce is based on the NAIC model reporting and is updated when the NAIC model changes.

E. Suggestions not recommended

As noted earlier, some suggested changes submitted by stakeholders fell outside the scope of this project. Every suggestion within the scope that was submitted by stakeholders up to the writing of the report was considered by state agency staff. Some suggestions were agreed upon, and others continue to be under consideration; these are included in this report. However, some suggestions were not found to be workable, at least under current conditions. Some reports suggested for elimination due to a perception of being obsolete still provide important information. Other reports suggested for

reduction or other simplification carry federal obligations that would not be met under the suggested change.

The fact that a suggested change might not be workable at present is not a reason to reject it entirely. Going forward, changes in the health care environment, particularly in federal regulation, may create opportunities to revisit potential changes.

II. Short-term recommendations

In this project, stakeholder and agency interaction made it apparent that some potential report simplifications had advantages that were well understood and had no obvious disadvantages that would preclude adoption within the next year or so. Other potential changes have apparent advantages but need further technical-level review for workability. All of these are included in this section. Other, longer-term changes need to be considered within the context of potential changes on the national level, and are included in the next section.

A. Eliminate or merge certain reports

The following reports and data submissions were reviewed during this project and are recommended for elimination. (*The accompanying numbers in brackets refer to the inventory attachment.*)

1. The MDH HMO Annual Report, Supplemental #2, which is completed by Health Maintenance Organizations (HMOs) and County-Based Purchasers (CBPs), can be eliminated. It is an annual summary of complaints and grievances reported by HMOs and CBPs. It includes public program enrollees such as Prepaid Medical Assistance (PMAP) and MinnesotaCare (MnCARE). The categories in the report are so broad that the resulting data is not informative. Monitoring of HMO and CBP complaints is done as part of the regular quality exams done by MDH as well as through investigation of complaints filed with MDH or DHS. Therefore this supplemental report is not necessary and can be eliminated. State authority: The report categories are delineated in Minnesota Rules 4685.2000, which would need to be repealed. [20]

2. The MDH HMO Annual Report, Supplemental #3, which is completed by HMOs, CBPs and insurance companies that use chemical dependency (CD) reviewers to deny CD claims, can be partially eliminated. It is a summary of chemical dependency claims and appeals. The report is not put to use; there are no standards by which to measure the numbers. Complaint investigation and quality exams provide more reliable compliance monitoring. Unlike some of the other Annual Report supplements, this one is not posted on the web, and the agencies do not get requests for the information. MDH may continue to have insurers file its specific evaluation standards and criteria, but eliminate the need to file the number of evaluations done, the types, the results, appeals and number of complaints. State authority: M.S. 72A.201, subd. 8(7); a repeal would be needed. [27]

3. The MDH HMO Annual Report, Supplemental #5, which is completed by HMOs, CBPs and insurance companies, can be eliminated. It lists the number and rate of medical necessity denials and appeals by utilization review organizations. The report is not put to use; there are no standards by which to measure the numbers. Complaint investigation and quality exams provide more reliable compliance monitoring. This supplemental also is not posted on the web and agencies do not get requests for the information. State authority: M.S. 62M.09, subd. 9; a repeal would be needed. [28]

4. DHS requires each MCO to collect and maintain all Evidence-based Childbirth Data Collection Forms completed by attending obstetric providers performing labor and delivery in hospitals that do not have approved policies and procedures related to elective inductions. The MCO must provide those forms to DHS at the end of the contract year for purposes of a comparative review among hospitals. The reporting requirement is structured so that if enough hospitals adopt policies that prohibit elective inductions prior to 39 weeks and receive approval of those policies, and it is determined that 90 percent of births take place in hospitals with approved policies, then the Commissioner of Human Services has the authority to discontinue a part of or all of the initiative and eliminate the reporting requirement. State authority: M.S. 256B.0625, subd. 3q. [29]

5. DHS Grant Reports providing both individual-level and summary data that measure program effectiveness and are used to complete federal block grant requirements will be eliminated as of January 2012. State authority: M.S. 245.4889, subd. 2. [79]

6. The MDH Supplemental #4 and the DHS Provider Network List both contain a list of participating providers from HMOs and CBPs. It is used to verify network adequacy and to determine location of provider types. One of the reports could be eliminated with the remaining report being revised to serve multiple purposes. Some issues to be resolved include timing: the MDH report is a snapshot of providers on Dec. 31 and the DHS report is submitted in April and updated in October to have the most current information available to policy areas such as Mental and Chemical Health, Dental, Aging and Continuing Care, Ombudsman, etc. To be useful to DHS the report would need to be separated by product or program. Merging the reports necessitates agency process changes. State authority: M.R. 4685.2100; M.S. 62D.124. [8, 45]

7. MDH collects high-five salary reports from HMOs and CBPs; these are either the IRS (Internal Revenue Service) Form 990 required of non-profits, or an equivalent disclosure of executive compensation required of all other health plan companies. The report can be eliminated; the agency no longer uses the information. State authority: M.S. 62Q.64. [13]

8. Home and Community-Based Services (HCBS) Quality Assurance Plans assuring DHS that lead agencies are administering HCBS programs according to state and federal requirements will be eliminated as of January 2012. [24]

9. DHS no longer has a need to collect the Third Party Liability – Personal Injury Settlement data from MCOs. This report will be eliminated and the 2012 contract will be amended to remove the monthly reporting requirement. [31]

B. Reduce or simplify certain reports

The following reports and data submissions were reviewed during this project and are recommended for reduction, modification, or other simplification. (*The accompanying numbers in brackets refer to the inventory attachment.*)

1. DHS requires review and approval of the MCO's Provider Directory. It lists all of the contracted providers in the MCO's network within the MCO's service area. The agency agrees that the information that is incorporated into this specific document is provided to the agencies in a couple of different reports and that those reports could be merged such as the Provider Network List that is collected by DHS and MDH. As previously mentioned in this report, one of the two documents is being considered for elimination. However, it is important to note that the merger of these two reports would not alleviate the MCO's requirement to compile and provide its provider directory for review and approval by DHS before the MCO sends it out to enrollees. DHS is considering using an existing MCO workgroup to review Provider Directory guidelines and requirements in an effort to reduce the review and approval process for both DHS and MCOs. [42]

2. MDH regulates Hospital Acquired Infection reporting that hospitals must submit to the Minnesota Hospital Association. It is recommended that the reporting system be modified so that it is consistent with Centers for Disease Control and Prevention (CDC) standards and definitions that hospitals use for other reports that CMS requires, rather than the current National Quality Forum (NQF) standards outlined in statute. This will require statutory change. State Authority: M.S. 62J.82. [25]

3. DHS Performance Improvement Project (PIP) reporting is used in the annual evaluation of MCO performance as required by federal regulation. The reports are very similar to the requirements of CMS Quality Improvement Program (QIP) reports. The 2012 DHS contracts for Minnesota Senior Health Options (MSHO)/Minnesota Senior Care Plus (MSC+) and Special Needs Basic Care (SNBC), will allow MCOs to use CMS' senior and dual-eligible Special Needs Plan (SNP) Medicare QIP projects to meet Minnesota's annual PIP contract requirement. The 2012 contract reflects this change and significantly simplifies and reduces the MCO's project reporting obligations. Federal authority: 42 CFR 438.240. [71]

4. DHS requires in its contract with the MCOs to annually report the MCO's Emergency Preparedness Response Coordinator (EPRC) to ensure that contact information is always current in the case of a disaster or emergency. DHS will amend the 2012 contract to only require MCOs to report when there has been a change in the appointment of the EPRC. Although not a significant reduction in

burden, it is an example of an ongoing effort to reduce overall reporting obligations. [44]

5. The MDH Annual Report, Supplemental #1 provides necessary information for a number of policy applications: DHS uses the information in its rate setting process and MDH for insurance market analysis. Some of the information may become redundant given likely revisions to other National Association of Insurance Commissioners regulatory filings. Also, some of the reporting elements are obsolete and need to be removed or revised. It should be noted that the changes that can be made at this point are somewhat minor but substantial reductions are anticipated in 2014, following anticipated federal health care reform efforts. State authority: M.S. 62D.08, subd. 3; a repeal is needed. [11]

6. The federal Children's Health Insurance Program Reauthorization Act (CHIP RA) of 2009 requires quarterly submission of dental provider data that is used for a national CMS website promoting children's access to dental services. CMS requires the data to ensure dental access for children in each state and identify health plans and dental providers accepting new patients. Minnesota's MCOs have minimal changes and would prefer reporting annually instead of quarterly. DHS did contact CMS regarding the frequency of this reporting requirement and asked if MCOs could report less than quarterly. CMS responded that the submission must be quarterly. DHS followed up with CMS about the possibility that if an MCO had no changes from the previous submission whether CMS would consider excluding them from the quarterly submission. CMS agreed that if the MCO had no changes from the previous submission that the MCO would not be required to submit the data but would be required to submit a data certification indicating that the previous quarter's submission is still current and that there have been no changes. MCOs would be required to submit the actual data annually and certify the other quarterly submissions if there were no changes from the initial submission for that contract year. CMS stated that an MCO could not simply skip a submission. DHS will communicate this change to MCOs and amend their contract to revise the language related to the submission of this data requirement. [40]

C. Complete the conversations

Most of the above recommendations to eliminate, merge, reduce or otherwise simplify specific reports have been discussed at length with stakeholders, and the agencies are beginning to initiate action. Most of the following recommendations, however, are ones where a basic or high level agreement has been reached but continuing examination and conversation – both within agencies and with stakeholders – is needed before any change can be made operational. It is the intent of the agencies to continue working on the recommendations that have been identified and, when remaining issues are resolved, to enact administrative changes as soon as practical. When appropriate, requests for statutory changes will be submitted to the Legislature for consideration.

Conversation will continue in other areas as well; for example, MDH has agreed to work with hospitals and their association on evaluating alternative data sources for reporting of

capital expenditures. In addition, stakeholders submitted some suggestions after the series of agency and stakeholder meetings were complete; conversations regarding some of those suggestions may need to continue. (*The accompanying numbers in brackets refer to the inventory attachment.*)

1. Both DHS and MDH have a process for the review and approval of the Evidence of Coverage (EOC). It is an important MCO document that is sent to enrollees as part of their enrollment materials that identifies covered services, cost-sharing, grievance and appeal process, referral and authorization requirements, enrollee bill of rights and responsibilities, and services that are not covered. Currently the report is submitted to both agencies. DHS and MDH have agreed to meet and look at their respective requirements for the EOC and determine how best to streamline the review and approval process of the EOC. State authority: M.S. 62D.07. [80]

2. The DHS Primary Care Network List (PCNL) Review and Approval is submitted by MCOs and is provided to potential enrollees at initial and open enrollment to assist them in selecting an MCO. As noted earlier, DHS already has reduced this report from a quarterly submission to a semiannual submission. MCOs would like to further simplify by eliminating the need for the cover letter that accompanies the PCNL and identifies the changes in their primary care network. The reason is that the MCOs provide information on providers that are no longer a part of the MCO network in other formats. However, the cover letter requires not only deletions from the network but any additional providers that have been added and serves as an affirmation that the information contained in the PCNL is accurate on the date submitted. In the past there have been issues with inaccurate information being published in the PCNL and the cover letter is a way to ensure that data is being reviewed and changes are being made. The cover letter also helps to expedite the review of this document. There may be other opportunities to further simplify this reporting process, and DHS is open to discuss with the MCOs what some of those opportunities are, as long as DHS continues to meet its obligation to ensure enrollees and potential enrollees are provided with specific information required under the federal managed care regulation. Federal authority: 42 CFR 438.10. [43]

3. Two MDH reports – Minnesota Statewide Quality Reporting and Measurement System and Health Care Home – require similar data submission streams coming through two portals. The former report includes submission of quality measures for clinics, ambulatory surgical centers and hospitals, and the latter requires physician clinics certified as health care homes to submit data on a subset of those measures with additional data elements for purposes of their annual certification. MDH has an effort underway to create a single data stream process, thereby reducing the reporting burden as well as the contractual overhead needed for collection of this data. This will benefit certified health care home clinics; there are about 145 such clinics now, with possibly 150 more to be added each year. State authority: M.S. 256B.0751 subd. 6 (and M.R. 4764.0040); and M.S. 62U.02 (and M.R. Ch. 4654). [21, 23]

4. MDH and DHS have agreed that MDH will work with DHS to provide it with the data necessary for its Health Care Delivery System (HCDS) demonstration project. MDH will share data gathered from the Statewide Quality Reporting and Measurement System for this purpose, thereby allowing the DHS HCDS demonstration project to make use of existing requirements and preemptively minimizing stakeholders' reporting burden. [23]

5. The MDH Changes in Participating Entities report and the DHS Actions Terminating Provider Participation report collect similar network adequacy data on spreadsheets that potentially could be combined into one spreadsheet. A full merger of the reports is not a simple matter. MCOs now reporting to DHS report provider terminations, which encompasses more than what MDH collects in their report from MCOs. DHS needs to collect not only providers who have been terminated from the MCO's network but must include in that report any provider that was not credentialed or re-credentialed or denied enrollment with the MCO. The two reports could be combined but there would have to be significant revisions to the MDH report in order for DHS to satisfy CMS' program integrity requirements. MDH and DHS have agreed to discuss their respective requirements to determine if the two agencies can streamline these two reports. State authority: M.S. 62D.08, subd. 5. [6, 41]

6. The MDH Capital Expenditure Report, which is a component within the MDH Hospital Annual Report but is also collected through separate mechanisms from other providers, requires detailed reporting on capital investments. Providers suggested that there is potential overlap with federal reporting under the Medicare Cost Report. With the help of certain hospitals and the hospital association, MDH plans to examine the federal report to evaluate ways to reduce the administrative burden for hospitals. If the Medicare Cost Report proves to be a potential source for collecting this relevant information, statutory change would be necessary to allow MDH to obtain this data elsewhere. It is possible that some data collection would need to remain in order to satisfy the requirement that the Department conducts the approval process. State authority: M.S. 62J.17. [14, 15, 16]

7. The MDH Hospital Annual Report is also critiqued by stakeholders who contend that unclear definitions lead to hospitals being inconsistent in how they submit data, effectively making the data meaningless. MDH has committed to working with hospitals and the MHA to identify whether and how the data can be improved. [18]

8. Commerce and MDH require health plans to submit data so that Commerce can prepare an annual report of Loss Ratio Experience in the Individual and Small Employer Markets. As reporting to federal agencies increases and the NAIC requirements evolve, the information required by the state may be captured as part of the national standards. The agencies have agreed to compare their data and work with health plans to simplify the Loss Ratio report, or possibly even eliminate it, as national reporting becomes available. State Authority: M.S. 62A.021 Subd. 1(h). [26]

9. Regarding the Child & Teen Check-ups report, MCOs provide well-child visit data to DHS that is compiled and shared with counties for appropriate follow-up. There are certain elements to this report that are not currently collected on encounter data, e.g. county of residence. There are also timing issues in using encounter data for this reporting requirement. MCOs have 90 days in which to submit encounter claims after they adjudicate their claims so this is problematic with providing counties with real time data for follow up with enrollees. However, DHS is looking at what is currently collected on encounter claims and will be reviewing the submissions to see if changes can be made to alleviate these issues. This is best addressed in the context of a comprehensive approach to expanding the use of encounter data. [32]

10. The MDH Supplemental #6, which gathers county-level enrollment data from HMOs and CBPs could be eliminated, provided MDH is able to obtain the same information from DHS for public programs including the integrated Medicaid/Medicare programs (MSHO and SNBC) and the equivalent information for commercial enrollees through alternative means. [9]

11. MDH is currently required to collect data on community benefit provided by Minnesota hospitals (this is part of the HAR). Until recently, this data was unique to Minnesota, both in scope and scale. The ACA requires that non-profit hospitals annually provide related information as part of their annual IRS filings. MDH will evaluate the extent to which this data can replace Minnesota reporting requirements for some or all of hospital providers and if so recommend statutory changes. Full reporting did not begin until after the tax year beginning March 23, 2010. This means MDH will likely not be able to complete its review until obtaining complete FY 2011 data by the end of CY 2012. State Authority: M.S. 144.669, subd. 5. [18]

D. Create purpose statements

There were two recommendations from stakeholders that were frequently repeated. One recommendation was that a particular report ought to be eliminated because it served no useful purpose. In the course of dialogue, state agency staff members often were able to explain how the data is used for compliance and policy making; and the stakeholder response was that no one had ever told them that.

A solution was proposed by a stakeholder in one of the meetings. It was noted that federal data submission reports frequently include a brief description of the purpose of the report at the top of their completion instructions. The recommendation is that instructions for state data submission requirements include a brief explanation or description of the data's primary purpose or the primary way that the information is used. The statement would be dated, so that stakeholders responsible for the report would know how long it has been since the purpose statement was revisited. Some regulatory reporting requirement documents for the three state agencies already include purpose statements; this recommendation would extend the practice to all documents.

Following is an example of a purpose statement for a federal data submission report; this is for the hospital inpatient quality reporting program (formerly known as the reporting hospital quality data for annual payment update program):

> "This information describes how acute-care hospitals paid for treating Medicare beneficiaries under the acute-care inpatient Prospective Payment System (IPPS), can receive the full Medicare Annual Payment Update in accordance with the Deficit Reduction Act of 2005. The payment update for Fiscal Year (FY) 2007 and each subsequent fiscal year will be reduced by 2.0% for any IPPS hospital that does not meet the Hospital IQR program requirements or chooses not to participate."

While stakeholder sentiment was expressed in favor of adding purpose statements to reports, stakeholder caution was expressed as it related to the potential of additional reports. The other repeated recommendation was to consider when data is collected for one purpose in one report, whether it could be used for other reporting purposes instead of being collected again in another report.

Stakeholders can support purpose statements if they are an administrative initiative on the part of the agencies. Their apprehension stems from a concern that if purpose statements are legislatively mandated, they may prescribe or limit the use of the data to only the stated purpose, and not allow agencies to eliminate or reduce other reports collecting the same or similar data.

III. Long term recommendations

Section II Short-term Recommendations include actions that can be initiated within the year or the following year. Section III addresses changes that are more long term and may take a longer period of time to accomplish.

A. Major change initiatives

In a sense, this project has examined reporting and data submission requirements with both a microscope and a telescope. On one hand, in looking for opportunities that can be initiated and possibly even completed within the next year, the effort has identified specific reductions and simplifications. On the other hand, the project has examined the potential for major, significant changes that can transform reporting and information sharing among health plans, health care providers, and public agencies.

In the past, large scale improvements tended to be associated with other changes, such as the movement from paper-based to web-based data gathering. In the future, large scale improvements may come from realigning reporting in conjunction with national and state-level health care markets, standard-setting and reform changes that are now in development. Stakeholders and agency staff members have identified the emergence of accountable care organizations (ACOs), health care homes, and changes in federal law as opportunities to rethink and reorder data needs. Numerous individual reports, as well as separate reporting portals and mechanisms could potentially be combined and simplified, resulting both in less procedural work and in more useful information. Within this opportunity is the potential capacity for better use of existing data sources, including encounter data and components of the Minnesota Statewide Quality Reporting and Measurement System, including measures originally developed by MN Community Measurement and CMS, Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient experience surveys, and Healthcare Effectiveness Data and Information Set quality measures.

The key words here are “potential” and “development.” The major health initiatives underway are still evolving and many variables are unknown, particularly pending federal standards and requirements. However, many of the specific short-term recommendations included in this report signify initial steps to prepare both agencies and stakeholders for larger-scale and longer-term reporting improvements over the next few years.

The large-scale change most frequently identified as a priority concern by stakeholders and agency staff alike is an expanded use of encounter data. That opportunity is described below.

B. Encounter data

Both MDH and DHS collect “encounter data” reflecting each encounter that an enrollee or insured patient has with the health care system.

The MDH encounter data is collected at least every six months from health plans and third party administrators with at least $3 million in medical claims. The data is de-identified and is housed in an All-Payer Claims Database (APCD) warehouse. This database also includes fee for service (FFS) Medicare data, Medicare Advantage data, MHCP (Minnesota Health Care Program) managed care data from the health plans and MHCP FFS that MDH obtains from DHS. This data is collected under statute to perform an analysis of the value of health care of Minnesota providers. [5]

DHS collects at least monthly encounter data from the health plans and their third part administrators for recipients enrolled in MHCP. This data is stored in the DHS enterprise-wide data warehouse. In addition DHS stores the claims information for MHCP recipients enrolled in FFS health care programs. The data warehouse includes data on all recipient eligibility and enrollment and service provider information. These data are required by federal regulations and are critical to administering and overseeing Minnesota's public health care programs. [30]

Encounter data is of particular interest to the effort of reporting simplification because it presents different opportunities for reporting. First, there are opportunities to reduce the reporting burden in data collection related to MHCP encounter data; and second, to use encounter data streams for broader purposes.

1. Simplified collection standards

Stakeholders have noted that the dual streams of encounter data for public program managed care claims create reporting burdens. MDH and DHS have committed to finding ways to ease the administrative burden and simplify encounter data collection. Reducing the reporting burden could occur by either moving to one data submission standard and format that is consistent across both agencies or by moving to one data submission process altogether. In the near term, the two agencies are moving toward a single national standard for reporting post-adjudicated medical claims data.

There is a nationwide effort to move toward national standards for submission of post-adjudicated claims data. This effort is headed by a joint initiative of the American National Standards Institute (ANSI) and the All-Payers Claims Database (APCD) Council. Several staff at DHS and MDH have been participating in the new standard guide development webinars sponsored by the APCD Council and ANSI X12 Standards Institute. According to the project schedule, the X12-837 Professional, Institutional and Dental post-adjudicated claim guides are to be posted for public comment by March 15, 2012. Staff at DHS, MDH and the Managed Care Organizations will begin to review and comment on the new submission guides as soon as they are released for public comment. The new standards will help determine the potential for more efficient collection of encounter data.

The emergence of national standards is a complicated process. A great deal of detail is not included in this report. Presuming the national standards meet the business needs of agencies, MDH and DHS have agreed to align their encounter data collection using the national standards.

DHS and MDH will also continue to assess the viability for moving to a single data submission for public program enrollees. As part of this effort, the two agencies will need to develop a plan for ensuring that each agency's needs for a highly secure, technically adequate data submission, editing, aggregation and storage solution are met.

Building these systems at the state level in order to reduce the number of submissions for data reporters doesn't make the data submission expenses disappear; rather, some significant administrative costs would be shifted to the state to facilitate a single data submission process. Until specific recommendations emerge from further agency and stakeholder dialogue, the cost of any reporting burden transition is unknown. The agencies will consider this issue further after the National Standard for the submission of post-adjudicated claims data is finalized and agreed upon by both agencies.

2. Report reduction

Broader use of either agency's encounter data potentially would facilitate a reduction in other types of reports submitted by health plans. It is important to note that any potential to use market-wide encounter data collected by MDH is currently prohibited by the legislative direction that this data be used *only* for the provider peer grouping analysis authorized under Minnesota Statutes 62U.04. Data is currently not accessible for any other purpose, and is protected by strict data security standards and data use policies. In addition, components of DHS encounter data on public programs are also restricted as non-public data. The limitations on components of DHS' encounter data prevent DHS from using its encounter data as an information source that could allow other reports to be eliminated. More flexible uses of either data set would require legislative action. Stakeholders have identified other reports that also might be candidates for elimination.

An example of a report that could potentially be eliminated with expanded use of encounter data is the DHS Child & Teen Check-up Report [32]. An example of a report that could be simplified is the MDH Health Plan Financial and Statistical Report [17]. Other reports, if examined on an element-by-element basis, may have opportunities for reduction. Examples include DHS reports such as Critical Access Dental Incentive Payment [33], Chemical Dependency Room and Board Services [35], and Federally Qualified Health Center/Rural Health Clinic Payment Data [36].

These changes, although desirable, are not quickly or easily accomplished. As noted earlier with the Child and Teen Checkup report, the demand for timely data will exert pressure on both MCOs and health care providers. With other reports, there is a hurdle in that not all of the data needed by state agencies is found in claims data – some of the data comes from separate accounting systems. It is important to also note that in order to use the encounter data in place of some existing reporting requirements, there will likely be a period in which agencies evaluate the effectiveness of using encounter data; during this period, reporting systems likely will need to operate in parallel. In addition, agencies

likely will incur new fiscal responsibilities in order to meet the obligations required under the law with the help of the encounter data.

A number of stakeholders have emphasized that the reason they want DHS to use public program encounter data to obtain information currently provided across an array of separate reports submitted by MCOs is because of the costs incurred both in personnel time and systems use to submit the encounter data. They are understandably interested in reducing those expenses.

While this report focuses only on current reporting obligations and potential for reducing or simplifying those current requirements, it is also important to note that carriers would be required to submit another stream of encounter data under proposed federal risk adjustment regulations. Risk adjustment would apply to individual and the small group market beginning in 2014 under these proposed rules. This potential separate submission can be avoided if existing market-wide data in Minnesota's APCD can be used for risk sharing-related purposes.

C. New report criteria

The legislation establishing this report's work group called for criteria to be used in determining whether to establish new reporting and data submission requirements. The criteria included in MN session law (Laws 2011, 1st Sp. Sess., Ch. 9, a. 6, s. 90 subd. 3) listed below must support the establishment of new reporting and data submission requirements only:

1. If required by a federal agency or state statute;
2. If needed for a state regulatory audit or corrective action plan;
3. If needed to monitor or protect public health;
4. If needed to manage the cost and quality of Minnesota's public health insurance programs; or
5. If a review and analysis by the commissioner of the relevant agency has documented the necessity, importance, and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report.

These specifics listed in the legislation offer, inherently, a set of criteria for any new reporting requirements. They provide a checklist in which an agency must determine that at least one of the criteria makes the new report necessary.

The elements in that checklist – accepting the legislative language as a given – basically covers much of what agency and stakeholder representatives generally have expressed about the reports and data submissions: No new reports should be requested unless the data is needed for a known purpose; and data shouldn't be requested if available elsewhere.

1. Criteria recommendation

The agencies have agreed the law establishes effective standards for the creation of new data submission requirements by stating that any new data submission requirement must meet one of the five criteria. Agencies also agree they will first see whether the specific information sought is already reasonably available through another state or federal report.

Discussions identified that there is a need for a common understanding of the terms in the statute. Different agencies may use different terminology and it is important that terms in the statute are defined broadly based on the function of the report. For example, it is assumed that criteria #2, permitting the establishment of reports for purposes of audits or corrective action plans, would also include all reports required by agencies in their oversight role of the entities they regulate, no matter whether the oversight mechanism is identified as an audit, a corrective action plan or some other term such as a regulatory examination.

These criteria address most of the concerns raised by stakeholders. Some other concerns that have been considered include:

- If a new report is federally required then, to the extent possible, the report should be limited to only what is required. A difficulty with this consideration is that some federal requirements are not prescriptive in what or how data is collected. It also could limit an agency's ability to merge and streamline multiple reports, an objective sought by stakeholders.

- New reports should have sunset provisions. Some stakeholders have asked for this, contending that legislators create new reports based on anecdotal information from constituents, resulting in ongoing reporting that is no longer used. Other stakeholders agreed with the assessment but not the solution, suggesting that sunsets become pro forma exercises.

- DHS should not require MCOs to submit any reports unless the agency requires the same reports of itself in its direct administration of the fee-for-service (FFS) program. However, there are structural differences; for example, the FFS program does not contract directly with provider networks from which enrollees must receive care, so provider network reporting is not necessary. Related to the FFS program, DHS does report regularly to CMS as required under the State Plan, and frequently provides data on cost, utilization and other program aspects to the legislature.

D. Continuing engagement

Agency staff members found value from the project's work group. It was a chance to simplify and improve their own agency's reports and data submissions, and it also provided a forum to better understand the roles and requirements of the other agencies. While some issues will be resolved within the next year, other issues will need further consideration. Other issues will arise as health care undergoes change on the national level.

As noted earlier in this report, state agencies already conduct a number of periodic interactions with stakeholders involved with specific reports. DHS, MDH and Commerce have agreed to initiate an annual meeting regarding: 1) the potential state impact from national data developments, 2) each agency's anticipated data-related changes for the coming year, 3) the status of ongoing improvement efforts, and 4) new joint possibilities for report simplification. Prior to the meeting, the agencies need to connect with stakeholders, providing them with ample opportunities to relate their concerns and suggestions regarding both current and anticipated reporting.

Some stakeholders did suggest that any ongoing improvement effort be much more formalized, involving authority delegation, appeals processes or other regulatory procedures. Most stakeholders, however, argued against any additional formality, observing that once change processes become formalized, they may become inflexible. Instead, stakeholders recommended that getting the agencies to sit down and discuss their concerns is the best improvement to recommend at this time.

IV. Attachments

Appended to this report are:

- Attachment A: Acronyms used in this report
- Attachment B: Minnesota Session Laws from the first special session 2011, chapter 9, article 6, section 90 (1Sp2011c9)
- Attachment C: Inventory of relevant Minnesota reports and data submissions provided by the departments of Human Services, Health and Commerce

Attachment A

Acronyms used in this report

ACO: Accountable Care Organization
ANSI: American National Standards Institute
APCD: All-Payer Claims Database
CAHPS: Consumer Assessment of Healthcare Providers and Systems
CBP: County-Based Purchaser
CDC: Centers for Disease Control and Prevention
CMS: Centers for Medicare & Medicaid Services
DHS: Minnesota Department of Human Services
FFS: fee for service
HMO: Health Maintenance Organization
IRS: Internal Revenue Service
MAD: Management Analysis & Development Division (of MMB)
MCO: Managed Care Organizations
MDH: Minnesota Department of Health
MHCP: Minnesota Health Care Programs
MMB: Minnesota Department of Management & Budget
MNCare: MinnesotaCare
MSHO: Minnesota Senior Health Options
MSHO/MSC+: Minnesota Senior Health Options/Minnesota Senior Care Plus
NAIC: National Association of Insurance Commissioners
NQF: National Quality Forum
PIP: Performance Improvement Project
PMAP: Prepaid Medical Assistance Program
QIP: Quality Improvement Program
SNBC: Special Needs Basic Care
SNP: Special Needs Plan

Attachment B

Minnesota Session Laws from the first special session 2011, chapter 9, article 6, section 90 (1Sp2011c9)

Sec. 90. **REGULATORY SIMPLIFICATION AND REDUCTION OF PROVIDER REPORTING AND DATA SUBMITTAL REQUIREMENTS.**

Subdivision 1. **Regulatory simplification and report reduction work group.** The commissioner of management and budget shall convene a regulatory simplification and report reduction work group of persons designated by the commissioners of health, human services, and commerce to eliminate redundant, unnecessary, and obsolete state mandated reporting or data submittal requirements for health care providers or group purchasers related to health care costs, quality, utilization, access, or patient encounters or related to provider or group purchaser, monitoring, finances, and regulation. For purposes of this section, the term "health care providers or group purchasers" has the meaning provided in Minnesota Statutes, section 62J.03, subdivisions 6 and 8, except that it also includes nursing homes.

Subd. 2. **Plan development and other duties.** (a) The commissioner of management and budget, in consultation with the work group, shall develop a plan for regulatory simplification and report reduction activities of the commissioners of health, human services, and commerce that considers collection and regulation of the following in a coordinated manner:

(1) encounter data;
(2) group purchaser provider network data;
(3) financial reporting;
(4) reporting and documentation requirements relating to member communications and marketing materials;
(5) state regulation and oversight of group purchasers;
(6) requirements and procedures for denial, termination, or reduction of services and member appeals and grievances; and
(7) state performance improvement projects, requirements, and procedures.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, shall present to the legislature by February 15, 2012, proposals to implement their recommendations.

Subd. 3. **New reporting and other duties.** (a) The commissioner of management and budget, in consultation with the work group and the commissioners of health, human services, and commerce, shall develop criteria to be used by the commissioners in determining whether to establish new reporting and data submittal requirements. These criteria must support the establishment of new reporting and data submittal requirements only:

(1) if required by a federal agency or state statute;
(2) if needed for a state regulatory audit or corrective action plan;
(3) if needed to monitor or protect public health;
(4) if needed to manage the cost and quality of Minnesota's public health insurance programs; or
(5) if a review and analysis by the commissioner of the relevant agency has documented the necessity, importance, and administrative cost of the requirement, and has determined that the information sought cannot be efficiently obtained through another state or federal report.

(b) The commissioners of health, human services, and commerce, following consultation with the work group, may propose to the legislature new provider and group purchaser reporting and data submittal requirements to take effect on or after July 1, 2012. These proposals shall include an analysis of the extent to which the requirements meet the criteria developed under paragraph (a).

Attachment C: Inventory of Reports and Data Submissions

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
	Agency	**Division / Section**	**Report / Data**	**Submitter (Complete Description)**	**Submitter: Hospital? (Y/N)**	**Submitter: Clinic? (Y/N)**	**Submitter: Individual Provider? (Y/N)**	**Submitter: Health Plan? (Y/N)**	**Submitter: Other Specified in Column D? (Y/N)**	**Frequency**	**Mode of Transmission (electronic, paper, direct data submission, etc.)**	**General Description**	**How is Data Used?**	**Individual-Level or Summary Data**	**Mandated / Voluntary / Contingent (pick 1)**	**State Mandate? (Y/N)**	**State Authority**	**Federal Mandate? (Y/N)**	**Federal Authority**	**Usage Restrictions? (if yes, briefly explain)**
1	Commerce	N/A	Annual Financial Statement & Supplements	Every insurance company doing business in this state (Chapter 60A) as well as Nonprofit Health Service Plan Corporations (Chapter 62C)	No	No	No	Yes	No	Annually, on or before March 1 of each year	Paper and Electronic. Filed with the Commissioner and with the National Association of Insurance Commissioners (NAIC)	Requirement to file NAIC annual statement blank, prepared in accordance with the association's instructions handbook and following those accounting procedures and practices prescribed by the NAIC's accounting practices and procedures manual, unless the commissioner requires or finds another method of valuation reasonable under the circumstances.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary Data; company level financial information vs. individually identifiable data	Mandated	Yes	Annual Statement, Inquiries, Renewal Licenses: MN Statutes, 60A.13 for insurance companies. Financial Statements and Examinations: MN Statutes 62C.11 for Nonprofit Health Service Plan Corporations	No	N/A, NAIC is not an enforcement authority	All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department. (60A.93).
2	Commerce	N/A	Risk Based Capital Report	A domestic "health organization" meaning a Minnesota health insurance company (Chapter 60A), a Nonprofit Health Service Plan Corporation (Chapter 62C), and a Health Maintenance Organization (Chapter 62D).	No	No	No	Yes	No	Annually, on or before April 1 of each year	Submit to the Commissioner of Commerce or Commissioner of Health (whichever agency regulates the health organization) and File with the National Association of Insurance Commissioners (NAIC)	Requirement to submit report of Risk Based Capital (RBC) levels as of the end of the calendar year just ended, in a form and containing the information required by the RBC instructions of the NAIC.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary Data; company level financial information vs. individually identifiable data	Mandated	Yes	RBC Reports: MN Statutes, 60A.51	No	N/A, NAIC is not an enforcement authority	All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department. (60A.93).

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T
	Agency	**Division / Section**	**Report / Data**	**Submitter (Complete Description)**	**Submitter: Hospital? (Y/N)**	**Submitter: Clinic? (Y/N)**	**Submitter: Individual Provider? (Y/N)**	**Submitter: Health Plan? (Y/N)**	**Submitter: Other Specified in Column D? (Y/N)**	**Frequency**	**Mode of Transmission (electronic, paper, direct data submission, etc.)**	**General Description**	**How is Data Used?**	**Individual-Level or Summary Data**	**Mandated / Voluntary / Contingent (pick 1)**	**State Mandate? (Y/N)**	**State Authority**	**Federal Mandate? (Y/N)**	**Federal Authority**	**Usage Restrictions? (if yes, briefly explain)**
3	Commerce	N/A	Quarterly Financial Statement	All Minnesota domestic insurers	No	No	No	Yes	No	Quarterly within 45 days of the end of the first three quarters (by 5/15, 8/15 and 11/15) for domestic insurers.	Paper and Electronic. Filed with the Commissioner and with the National Association of Insurance Commissioners (NAIC)	Requirement for domestic companies to submit quarterly statements.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary Data; company level financial information vs. individually identifiable data	Mandated	Yes	Annual Statement, Inquiries, Renewal Licenses: MN Statutes, 60A.13	No	N/A, NAIC is not an enforcement authority	All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department. (60A.93)
4	Commerce	N/A	Audited Financial Statement	Every insurance company doing business in this state (Chapter 60A) as well as Nonprofit Health Service Plan Corporations (Chapter 62C). Foreign and alien insurers exempt if filing audited financial reports in another state found by the Commissioner to be substantially similar.	No	No	No	Yes	No	Annually, by June 1 for the immediately preceding year ending December 31.	Paper and Electronic. Filed with the Commissioner and with the National Association of Insurance Commissioners (NAIC)	Requirement to have an annual audit performed by an independent certified public accountant and file a report of this audit with the Commissioner.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary Data; company level financial information vs. individually identifiable data	Mandated	Yes	Annual Audit: MN Statutes, 60A.1291	No	N/A, NAIC is not an enforcement authority	All financial analysis ratios and examination synopses concerning insurance companies that are submitted to the department by the National Association of Insurance Commissioners' Insurance Regulatory Information System are confidential and may not be disclosed by the department. (60A.93)

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5	Health	HEP 08	Minnesota Health Care Claims Reporting System (encounter data)	Health plans, third party administrators, and DHS	No	No	No	Yes	No	At least every six months	Electronic Secure Upload	Health plans and third party administrators with at least $3M in medical claims must submit data at least every six months to an external vendor under contract with MDH. The all-payer claims database also includes FFS Medicare data, Medicare Advantage and MHCP managed care data from health plans, and FFS MHCP data from DHS.	This data is used to provide health care consumers and purchasers more transparency about the combined metric of cost and quality, to provide incentives for greater use of higher-value health care providers. Ultimately, the data serves the purpose to create payment systems that focus on delivering high-value health care (quality and cost).	Individual	Mandated	Yes	Minnesota Statutes, section 62U.04 and Minnesota Rules, Chapter 4653	No	N/A	Yes; Public reporting for explicit use by DHS/MMB in their structuring of provider network and incentivizing use of high value providers
6	Health	CM 12	Changes in participating entities	HMOs and CBPs	No	No	No	Yes	No	Varies	Electronic and paper	Cancellation or discontinuation of a provider contract.	Monitor continuing adequacy of the network and identify need for corrective action should the network seem deficient.	Summary	Mandated	Yes	Minnesota Statutes 62D.08, subdivision 5	No	N/A	No
7	Health	CM 13	New or amended corporate documents, service areas, certificates of coverage, provider contracts, various policies and procedures	HMOs and CBPs	No	No	No	Yes	No	Varies	Electronic and paper	New or amended documents need MDH approval before they can be used.	Review for compliance with applicable law and rules.	Summary	Mandated	Yes	Minnesota Statutes 62D.08, subdivision 1 and Minnesota Rules 4685.33	No	N/A	Yes, some might be nonpublic data
8	Health	CM 05	Supplemental #4	HMOs and CBPs	No	No	No	Yes	No	Annually	Electronic and paper	List of participating providers as of 12/31	Used to verify or determine adequacy of the provider network in all parts of the approved service area.	Summary	Mandated	Yes	Minnesota Rules 4685.2100	No	N/A	No
9	Health	CM 07	Supplemental #6	HMOs and CBPs	No	No	No	Yes	No	Annually	Electronic	Enrollment by demographic group, age, gender and enrollee months of participation.	Used to determine payment rate when renew certificate.	Summary	Mandated	Yes	Minnesota Statutes 62D.08, subd 3	No	N/A	No
10	Health	CM 01	Annual Report	Health Maintenance Organizations (MCOs) and County Based Purchasers (CBPs)	No	No	No	Yes	No	Annually	Electronic and paper	Financial report following NAIC blanks and requirement.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary	Mandated	Yes	Minnesota Statutes 62D.08	No	N/A	No

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11	Health	CM 02	Annual Report: Supplemental #1	HMOs and CBPs	No	No	No	Yes	No	Annually	Electronic	Statement of revenue, expenses and net income.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary	Mandated	Yes	Minnesota Statutes 62D.08, subdivision 3	No	N/A	No
12	Health	CM 08	Unaudited quarterly financial reports	HMOs and CBPs	No	No	No	Yes	No	30 days after quarter end	Electronic and paper	NAIC reports ## 1, 2 and 3; description of enrollment data included in NAIC report #4.	Monitor financial solvency and compliance with statutory solvency requirements.	Summary	Mandated	Yes	Minnesota Rules 4685.1980 and Minnesota Statutes, 62D.08, subdivision 6	No	N/A	Yes, held as nonpublic data
13	Health	CM 11	High five salary reports	HMOs and CBPs	No	No	No	Yes	No	Annually	Electronic	Copies of the IRS form 990 or equivalent disclosure of executive compensation.	Posted to the web for general availability.	Summary	Mandated	Yes	Minnesota Statutes 62Q.64	No	N/A	No
14	Health	HEP 01	Capital Expenditure Report (CER Information)	Health Care Systems, Other Providers	Yes	Yes	Yes	No	Yes	Annually	Electronic Secure Upload or email	All health care providers must report major capital spending commitments to the Minnesota Department of Health on an annual basis as part of existing financial and statistical reports. Capital Expenditure data for project commitments greater than one million dollars are collected in the Health Care Systems and Other Providers report.	Data is used to conduct retrospective (and prospective) review of capital expenditure commitments by Minnesota health care providers. It serves as a source to conduct analysis on trends in capital expenditures, including competition over new medical equipment and the placement on new clinics and other health care facilities.	Summary	Mandated	Yes	Minnesota Statutes, section 62J.17	No	N/A	No
15	Health	HEP 02	Diagnostic Imaging Utilization Report (DI)	Diagnostic Imaging Providers, Clinics, and Clinic Systems, Mobile Imaging Providers, Physician Practices, Freestanding Outpatient Surgical Centers	No	Yes	Yes	No	Yes	Annually	Electronic Secure Upload or email	Data are collected from all clinics, imaging facilities, and mobile imaging providers that provide or bill for Diagnostic Imaging services such as MRI, PET, CT, and SPECT. Capital Expenditure data for project commitments greater than one million dollars are collected in the Diagnostic Imaging report.	Data is used to identify trends in the number of machines diagnostic imaging equipment (MRI, CT, PET and combination scans) and their use in Minnesota facilities. It also a vehicle for verifying the extent to which there is physician economic interest in physician referral to imaging services that may or may not affect patient referrals.	Summary	Mandated	Yes	Minnesota Statutes, section 144.565	No	N/A	No

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16	Health	HEP 03	Freestanding Outpatient Surgical Center Report (FOSC)	Ambulatory Surgical Center	No	No	No	No	Yes	Annually	Electronic Secure Upload or email	Freestanding Outpatient Surgical Center (FOSC) financial, utilization, and services data is collected through an annual report, the FOSC Annual Report. All licensed surgical centers are required to complete the FOSC report and submit copies of their Audited Financial Statement and Medicare Cost Report. Capital Expenditure data for project commitments greater than one million dollars are collected in the FOSC report.	The data is used to analyze trends in revenue, expenses and utilization of freestanding surgery centers. Together with the HAR, this data provides the basis of analyzing trends of surgeries provided in Minnesota.	Summary	Mandated	Yes	Minnesota Statutes, sections 144.695 - 144.703, 144.562, 144.564, 62J.321 and Minnesota Rules, chapter 4650	No	N/A	Yes
17	Health	HEP 04	Health Plan Financial and Statistical Report (HPFSR)	Health Plans	No	No	No	Yes	No	Annually	Electronic Secure Upload or email	Data are collected annually from health plan companies (group purchasers) providing health coverage for Minnesota residents on the HPFSR. These data include enrollment, revenue, and costs. Administrative costs are summarized annually for companies with over $3,000,000 in annual healthcare revenue. Prescription Drug purchase data are collected annually from licensed hospitals and health plan companies (group purchasers) in Minnesota. These data include total spending, discounts, and rebates. Prescription Drug Purchases data are collected in the HPFSR.	This data is used to construct historical estimates of health care spending in Minnesota. It also forms the basis for MDH to calculate legislatively required projections of health care spending under the assumption that Minnesota health reforms were never passed, i.e., it forms one prong in the attempt to evaluate the effectiveness of Minnesota health reforms. The data is also used to supplement nationally available data on the size of the health care market, health plan market shares, and administrative costs.	Summary	Mandated	Yes	Minnesota Statutes, section 62J.38, Minnesota Statutes, section 62J.321, and Minnesota Rules, chapter 4652.	No	N/A	Yes

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18	Health	HEP 06	Hospital Annual Report (HAR)	Hospitals	Yes	No	No	No	No	Annually	Electronic Secure Upload from data collection vendor (Minnesota Hospital Association)	Hospital financial, utilization, and services data is collected through an annual report, the Hospital Annual Report (HAR). All hospitals (excluding federal hospitals) are required to complete the HAR and submit copies of their Audited Financial Statement and Medicare Cost Report. All health care providers must report major capital spending commitments to the Minnesota Department of Health on an annual basis as part of existing financial and statistical reports. Capital Expenditure data for project commitments greater than one million dollars are collected in the HAR. Prescription Drug purchase data are collected annually from licensed hospitals and health plan companies (group purchasers) in Minnesota. These data include total spending, discounts, and rebates. Prescription Drug Purchases data are collected in the HAR.	This data is used for multiple policy purposes, including informing the legislature of the effect of public program rate changes; calculating the Medicaid Surcharge; assisting the MN Department of Labor & Industry in their workers compensation provider rate negotiation; conducting legislative studies; and publishing research briefs and reports on hospital finances, utilization, services and community benefit.	Summary	Mandated	Yes	Minnesota Statutes, sections 144.695 - 144.703, 144.562, 144.564, 62J.321	No	N/A	Yes

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19	Health	HEP 05	Data collection and Research Initiatives to monitor and improve the efficiency and effectiveness of health care in Minnesota.	Health plans and providers	Yes	Yes	Yes	Yes	Yes	Periodically	Various	MDH has general responsibilities related to monitoring and improving the efficiency and effectiveness of health care in Minnesota through performing data collection research and information dissemination on health care delivery, outcomes, costs, quality, and management. As part of the responsibility to conduct timely research on new health care market trends, MDH is authorized to collect data from health plan companies and providers on a variety of measures. MDH has used this authority to respond to legislative requests for research on topics including trends in health plan community benefits, enrollment and benefits in the small group and individual market, the distribution of inpatient beds by specialty, and mental health capacity in the state.	The data informs publication of issue papers, presentation slides and legislative reports. It further informs MDH's work on policy issues, including the Legislative Health Care Access Commission's Small Group Market workgroup, micro simulation modeling on health reform and the development of fiscal notes.	Summary	Voluntary	No	Minnesota Statutes, section 62.301 and 62J.38.	No	N/A	Various
20	Health	CM 03	Annual Report: Supplemental #2	Health Maintenance Organizations (HMOs) and County Based Purchasers (CBPs)	No	No	No	Yes	No	Annually	Electronic	Summary of complaints received by the plan in the previous year.	Monitor plan's compliance with complaint and appeal requirements of state law.	Summary	Mandated	Yes	Minnesota Rules 4685.2000	No	N/A	No
21	Health	CFH 01	Health Care Home	Personal clinician or primary care clinic who requests to be certified as a Health Care Home; Certification is voluntary	No	Yes	Yes	No	No	At time of certification / re-certification. Evaluation data varies	Electronic, paper collected at site visit.	Data collected to monitor compliance with certification standards and for evaluating the impact of health care homes on health care quality, cost, and outcomes.	Clinics submit data on a voluntary basis to request certification as a health care home. Certified clinics are eligible for a per patient care coordination payment, and participate in ongoing measurement. Clinics are recertified annually. Largely the measurement work of the HCH is aligned with the quality rule to reduce administrative burden.	Patient level data (with no identifiers) collected at the physician / clinic level. Minnesota Community Measurement is contracted to collect the data.	Voluntary	No	Minnesota Statutes 256B.0751, subd. 6 and Minnesota Rules 4764.0040	No	N/A	No

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22	Health	CM 09	Healthcare Effectiveness Data and Information Set (HEDIS) quality reports	HMOs and CBPs (Other: NAIC collects from the plans and submits to MDH)	No	No	No	Yes	Yes	Annually	Electronic	Reporting of plan data specific to product lines and effectiveness of care measures.	For research by MDH and any other interested parties including the plans themselves, to measure improvements from year to year; to identify areas in need of attention.	Summary	Mandated	Yes	Minnesota Statutes 62D.08, subdivision 3	No	N/A	No
23	Health	HEP 07	Minnesota Statewide Quality Reporting and Measurement System	Physician Clinics and Hospitals	Yes	Yes	Yes	No	No	Varies according to the specific measure reported; most physician clinic measures are reported annually and most hospital measures are reported quarterly	Electronic Secure Upload or email	Clinical quality measure data were reported by approximately 520 physician clinics; Approximately 130 hospitals reported data on roughly 40 measures	This data is used to provide health care consumers and purchasers more transparency about the relative quality of services delivered by health care providers. It is also an input into the Quality Incentive Payment System, a pay-for-performance system used by MMB and DHS that is intended to reward high-quality providers and providers who make significant gains in health care quality. Ultimately, the data serves the purpose to provide health care providers information about their own performance and incent them to make improvements, if necessary.	Summary	Mandated	Yes	Minnesota Statutes, section 62U.02 and Minnesota Rules, Chapter 4654	No	N/A	No
24	Health	AASD/ HCBS Policy Integration	Home and Community-Based Services Quality Assurance Plans	Health Plan/ MSHO and/or MSC+ program	No	No	No	Yes	No	Biannually	Electronic submission via a web-based survey	The Home and Community-Based Services Quality Assurance Plan (HCBS QA Plan) is submitted by each county, tribe or managed care organization (MCO), referred to as a "lead agency", that administers the Long Term Care Consultation (LTCC), Alternative Care (AC), Elderly Waiver (EW), Community Alternatives for Disabled Individuals (CADI), Developmental Disabilities Waiver (DD), Traumatic Brain Injury (TBI), and Community Alternative Care (CAC) programs.	The HCBS QA Plan Survey provides assurances to DHS that the lead agency is administering the HCBS programs according to state and federal requirements.	Organizational-level data	Mandated	Yes- Via DHS contract with health plans	MSHO/MSC+ Contract	No	No	No

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25	Health	IPEPC/ADIC	Hospital-specific performance on the public reporting measures for hospital-acquired infections.	Hospitals	Yes	No	No	No	No	Quarterly	Electronically to the Minnesota Hospital Association (MHA)	As of January 1, 2009, hospitals must report their performance on public reporting measures for hospital-acquired infections as published by the National Quality Forum and collected by the Minnesota Hospital Association and Stratis Health in collaboration with hospital infection control practitioners. MHA was required to develop a web-based system where these data are available to the public free of charge.	Data are published on the MHA website so that the public can compare hospital performance.	Summary	Mandated	Yes	Minnesota Statutes, section 62J.82	The Centers for Medicare and Medicare Services (CMS) has made certain health-care associated infections reportable by in-patient prospective payment system hospitals. However, CMS is using different definitions than those required by Minnesota Statute. Specifically CMS is using National Health Care Safety Network defintions and Minnesota is using National Quality Forum definitions.	Inpatient Prospective Payment System (IPPS) Fiscal Year (FY) 2009 Final Rule under Section 5001(c) of the Deficit Reduction Act.	No
26	Health and Commerce		Loss Ratio Experience in the Individual and Small Employer Markets	Health Plans (insurance companies and HMOs)	No	No	No	Yes	No	Annually	Electric	Actual loss ratios experienced in the individual and small employer markets in Minnesota by health plan companies	Used to produce an annual public report	Summary	Manated	Yes	62A.021 Subd.1(h)	No	N/A	No
27	Health and Commerce	CM 04	Annual Report: Supplemental #3	HMOs, CBPs and insurance companies	No	No	No	Yes	No	Annually	Electronic	Summary of chemical dependency claims and appeals.	Track chemical dependency claims and appeals.	Summary	Mandated	Yes	Minnesota Statutes 72A.201 subd. 8 (7)	No	N/A	No
28	Health and Commerce	CM 06	Annual Report: Supplemental #5	HMOs, CBPs and insurance companies	No	No	No	Yes	No	Annually	Electronic	Number and rate of medical necessity denials and appeals by utilization review organizations.	Track number and rate of medical necessity denials and appeals.	Summary	Mandated	Yes	Minnesota Statutes, 62M.09, subdivision 9	No	N/A	No

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29	Human Services		Evidence Based Childbirth Report	Managed Care Organizations (MCOs)	No	No	Yes	Yes	No	Physician will submit the documentation with the claim for labor and delivery. MCO will submit all documentation received from physicians at the end of the calendar year.	Attachment to Claim	Attending obstetric providers performing labor and delivery in hospitals that do not have approved policies and procedures prohibiting elective preterm inductions must in accordance with Minnesota Statutes 256B.0625, subd. 3g submit information about the nature of the labor and delivery including any induction of labor that was performed in conjunction with that specific birth.	To produce annual report on preterm elective induced births. Data will be used to augment quality improvement efforts aimed at reducing preterm elective inductions.	Individual	Mandated	Yes	Evidence-based Childbirth Program Minnesota Statutes, 256B.0625, subd. g	No	No	No
30	Human Services	PSD	Encounter Data Submission	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Monthly	Electronic	Individual enrollee-specific, claim-level encounter data for services provided by the MCO to enrollees detailing all medical and dental, diagnostic and treatment encounters, all pharmaceuticals, supplies and medical equipment dispensed to enrollees, and all nursing facility services for which the MCO is responsible.	Used to calculate withhold and incentive payments, analysis for determination of capitation payment rates, business and policy area analyses, fiscal notes, and federal reporting.	Individual	Mandated by Contract	No	No	Yes	1903(m)(2)(A)(xi) of the SSA, 42 USC §1396b (m)(2)(A)(xi)	Some restriction on the use of certain fields such as the allowed and paid amount fields. These fields are classified as nonpublic data under Minnesota Statutes §13,02.
31	Human Services	PSD	Third Party Liability - Personal Injury Settlements	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Monthly	Paper - If MCO does not report the information in encounter data	Provide individual information on accidents and personal injuries.	Used to identify payers for health care costs other than Medical Assistance, the payer of last resort.	Individual	Mandated by Contract	No	No	Yes	[insert]	No
32	Human Services	PSD	Child & Teen Checkups (C&TC)	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Monthly	Electronic	Provide well-child visit data identified by codes specified by the State on all managed care enrollees under the age of 21.	The data is compiled by DHS and provided to the counties for appropriate follow-up.	Individual	Mandated by Contract	Yes	State Medicaid Manual 5122-5123.2	Yes	42 CFR §441.56	No
33	Human Services	PSD	Critical Access Dental Incentive Payment Report	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provide the total payment amount each quarter for each designated critical access dental provider.	The data is used by the State to determine the incentive payment for that dental provider.	Individual Providers	Mandated by Contract	Yes	Minnesota Statutes §256B.0625, subd. 4 and §256L.11, subd. 7	No	No	No

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34	Human Services	PSD	Reporting of Recoveries	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provide reimbursement data collected from third parties.	Used by the Financial Operations Division to report the collection of cost avoidance for the CMS-64, which is a report that allows DHS to collect federal participation.	Summary Data - Amounts collected from third party payers.	Mandated by Contract	No	No	Yes	[insert]	No
35	Human Services	PSD	CD Room and Board Services	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Identifies the chemical dependency residential services provided and paid for by the MCO.	The report is used to reimburse the MCO for these services which are not included in their capitation payment.	Individual	Mandated by Contract	Yes	Minnesota Statutes §254B.04, subd. 2a and Minnesota Statutes §254B.05, subd. 1.	Yes	42 CFR §8.12	This information would be classified as confidential.
36	Human Services	PSD	Federally Qualified Health Center (FQHC)/Rural Health Clinic (RHC) Payment Data	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Monthly	Electronic	Identifies MCO payments made to FQHCs and RHCs for all programs covered under the contract. Federal law requires supplemental payment for FQHC/RHC services covered under the managed care contract.	The data is used in calculating the settle-up payment required under federal law.	Individual Providers	Mandated by Contract	Yes	Minnesota Statutes §256B.0625, subd. 30	Yes	Title XIX Section 1905(l) of the SSA	No
37	Human Services	PSD	Health Care Services Expenditure Report	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	Provides data on health care services expenditures for the previous fiscal year under all Minnesota Health Care Programs (MHCP) contracts.	The data is used to certify to MMB the state share of tobacco use attributable costs for the previous fiscal year in Minnesota Health Care Programs.	Summary Data - Program Expenditures	Mandated by Contract	Yes	Minnesota Statutes §16A.725	No	No	No
38	Human Services	PSD	Health Care Home; Alternative Models Description	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCOs are required to provide descriptions of each comprehensive payment arrangement and the outcome and performance measures that it uses as an alternative to Health Care Homes. Integrated Medicare/Medicaid MCOs serving dual eligible are allowed to have alternative payment methodologies for health care homes which also need to be reported to DHS.	DHS uses this information to track implementation of enrollee access to health care home and compliance with the health care home statute.	Summary Data - Description Information	Mandated by Contract	Yes	Minnesota Statutes §256B.0751	No	No	Yes - The payment information provided is considered proprietary.

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39	Human Services	PSD	Provider Payment Rates Report	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must annually report to DHS information on reimbursement rates paid to providers and vendors for administrative services, the process by which increases or decreases in payments to the MCO related to provider costs increases or decreases, aggregate provider payment data, legislatively mandated provider rate changes, and data on provider reimbursement rates and rate methodologies.	The report data is analyzed by DHS and provided in a legislative report to the Legislature every December to assist the Legislature in providing oversight and accountability related to expenditures by MCOs. The analysis must include information on payments to physicians, physician extenders, and hospitals, and may include other provider types as determined by DHS. The report shall also array aggregate provider reimbursement rates by MCO, by primary care, and by no primary care categories.	Summary Data - Provider Payments	Mandated by Contract	Yes	Minnesota Statutes §256B.69, subd. 9b (b)	No	No	Yes - The payment information provided by the MCOs is protected under the statute and is considered non-public data under Minnesota Statutes §13.02.
40	Human Services	PSD	Dental Children's Health Insurance Program Reauthorization Act of 2009 (CHIP RA)	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provides specific information about dental providers in the MCO's network and certifies the data submitted.	The data is used for a CMS website to promote and improve childrens' access to dental services.	Individual Providers	Mandated by Contract	No	No	Yes	501(e) of Children's Health Insurance Plan Reauthorizatio n Act (CHIP RA)	No
41	Human Services	PSD	Actions Terminating Provider Participation	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provides data on all providers whose participation has been denied by the MCO through enrollment, credentialing or recredentialing or other reasons the MCO has terminated or not renewed the contract.	This data is used to comply with CMS program integrity standards.	Individual Providers	Mandated by Contract	No	No	Yes	42 CFR §455.106	No
42	Human Services	PSD	Provider Directory Review and Approval	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The Provider Directory lists all of the contracted providers in the MCO's network within the MCO's service area, including: primary care providers; specialty and sub-specialty providers; hospitals; nursing homes; and home and community-based providers. Providers' names, locations, telephone numbers and other requirements are also listed.	The document is used to meet federal requirements and to provide enrollees a list of providers, type of specialty, the location of those providers, languages spoken by providers, and whether they are accepting new patients.	Summary Data	Mandated by Contract	No	No	No	42 CFR §438.10	No

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43	Human Services	PSD	Primary Care Network List Review and Approval	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Biannually	Electronic	Identifies the MCO's Primary Care Provider Network within its service area.	The information is provided to potential enrollees at initial enrollment and enrollees during open enrollment to assist the enrollee in selecting a MCO.	Individual Providers	Mandated by Contract	No	No	Yes	42 CFR §438.10	No
44	Human Services	PSD	Emergency Preparedness Response Coordinator (EPRC)	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must appoint and identify an Emergency Preparedness Response Coordinator (EPRC). The MCO must notify DHS of any changes in the appointment of the EPRC.	The information is used as the contact for DHS with regard to emergency preparedness and response issues, and shall provide updates to DHS as the Emergency Preparedness Incident unfolds.	Summary Data - Information	Mandated by Contract	No	No	No	No	No
45	Human Services	PSD	Provider Network List - All participating providers	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must submit a complete list of participating providers, including name, specialty and address. Pharmacies, transportation providers and interpreters are excluded from this list.	This information is used to monitor the MCO's network access, capacity and adequacy.	Individual Providers	Mandated by Contract	Yes	Minnesota Statutes §62D.124	Yes	42 CFR 438.10	No
46	Human Services	PSD	Terminations and Additions to Care Systems, Care Coordination and Case Management System Entities	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO notifies DHS of the terminations or additions to its contracted Care System, County Care Coordination System and Case Management System entities.	DHS uses this information to oversee the adequacy and capacity of the MCO to provide care coordination that meets the special needs of its enrollees. It is also used to comply with oversight responsibilities under the 1915 (c) waiver and the network adequacy required by the Balanced Budget Act (BBA).	Summary Data - Report	Mandated by Contract	No	No	Yes	1915 (c) Waiver and 42 CFR 438.10	No
47	Human Services	PSD	MCO Solvency Standards	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must provide a written assurance to DHS annually and any time thereafter, that its provision against the risk of insolvency is adequate to ensure that its enrollees will not be liable for the MCO's debts if it become insolvent.	This information is required from the MCO to ensure that enrollees will be protected from liability of payment in case of MCO insolvency.	Summary Date-Letter of Assurance	Mandated by Contract	No	No	Yes	42 CFR 438.106	No

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48	Human Services	PSD	Financial Filing w/Minnesota Department of Health (MDH)	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO is required to certify either that in its annual statutory financial filing with the Minnesota Department of Health the filing represents only those costs related to services covered under the State Plan including the MCO's administrative costs, or certify and report the dollar value of each specific service that is a non-State Plan service.	This information is used In the rate-setting process to determine what percentage of the MCOs costs were not for services covered under the State Plan and make an adjustment in the rates for that.	Summary Data - Certification	Mandated by Contract	No	No	Yes	42 CFR §438.6(c)4	No
49	Human Services	NFRP	Single-bed incentive	Nursing facilities	No	No	Yes	No	No	When a rate adjustment for creating a single-bed room is desired	Electronic (by email) or paper (through US mail)	A nursing facility that closes a bed and at the same time creates a single-bed room can get a special rate adjustment for doing this. They must request it, however.	To compute the rate adjustment.	Facility specific data	Contingent	Yes	MS 256B.431, subd. 42	No		No
50	Human Services	NFRP	Performance Incentive Payments Program (PIPP)	Nursing facilities	No	No	Yes	No	No	When a rate adjustment for participating in PIPP is desired.	Electronic (by email) or paper (through US mail)	A nursing facility or group of nursing facilities that have an idea for a quality improvement program they apply for a rate increase to pay for the pilot of their idea.	To decide if the idea has merit and to compute the rate adjustment.	Facility specific or facility group data	Contingent	Yes	MS 256B.434, subd. 4, paragraph (d)	No		Yes. Funds must be used for the proposed program
51	Human Services	NFRP	Annual cost report	Nursing facilities	No	No	Yes	No	No	Annually	Electronic (through Internet)	A report of cost and statistical data for the most recent year ending on September 30.	To compute rates, analyze the financial health of the industry, and provide analysis for legislative proposals.	Facility specific data	Mandated	Yes	MS 256B.441	No		No
52	Human Services	NFRP	Employee scholarships	Nursing facilities	No	No	Yes	No	No	Annually	Electronic (through Internet)	A report of employees that had scholarship expenses paid by the facility to further their career in long-term care.	To compute allowable scholarship expenses to be included in the payment rates.	Individual	Contingent	Yes	MS 256B.431, subd. 36	No		No
53	Human Services	NFRP	Construction projects	Nursing facilities	No	No	Yes	No	No	When a rate adjustment for completing a construction project is desired	Electronic (by email) or paper (through US mail)	A facility that adds capital assets can request a rate adjustment to cover the expenses.	To compute a rate adjustment.	Facility specific data	Contingent	Yes	MS 256B.434, subd. 4f, 144A.071, and 144A.073	No		No

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54	Human Services	NFRP	MA single bed payment	Nursing facilities	No	No	Yes	No	No	When a rate add-on for a MA person in a single-bed room is desired	Electronic (by email) or paper (through US mail)	A facility who has an MA resident who needs a single-bed room by a physician's orders can apply for a rate increase.	To compute a rate adjustment.	Facility specific data	Contingent	Yes	MR 9549.0070, subpart 3	No		No
55	Human Services	NFRP	Ventilator dependent rates	Nursing facilities	No	No	Yes	No	No	When a rate adjustment for providing care to a ventilator-dependent resident is desired	Electronic (by email) or paper (through US mail)	Facilities that care for ventilator-dependent resident incur extra costs. They can apply for a rate adjustment to cover those costs.	To compute a rate adjustment.	Individual specific data	Contingent	Yes	MS 256B.431, subd. 2e	No		No
56	Human Services	NFRP	Case-mix conversion	Nursing facilities	No	No	Yes	No	No	When a change is made in the number of Resource Utilization Groups (RUG) to be used for nursing facility payments.	Electronic (by email) or paper (through US mail)	Occasionally (three times since 2002) there have been changes in either the number of RUGs to be recognized in rate setting or a change in the weightings of each RUG.	To compute rates.	Summary Data	Mandated	Yes	MS 144.0724	Yes		No
57	Human Services	PSD	Reporting of Denial, Terminations and Reductions (DTRs)	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Direct data	Provides data on all DTRs issued in the previous quarter.	This report is used to monitor MCO performance and compliance.	Individual	Mandated by Contract	Yes	Use federal standard to meet state statute	Yes	42 CFR §438.404	No
58	Human Services	PSD	Reporting of Grievances	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provides data on all oral and written grievances resolved in the previous quarter.	This report is used to monitor MCO performance and compliance.	Individual	Mandated by Contract	Yes	Use federal standard to meet state statute	Yes	42 CFR §438.406 & 408	No
59	Human Services	PSD	Reporting of Appeals	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Quarterly	Electronic	Provides data on all oral and written Appeals resolved in the previous quarter.	This report is used to monitor MCO performance and compliance.	Individual	Mandated by Contract	Yes	Use federal standard to meet state statute	Yes	42 CFR §438.406 & 408	No

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60	Human Services	PSD	Marketing Materials Review and Approval	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Anytime	Electronic	The MCO must present to DHS all marketing materials for approval, including but not limited to posters, brochures, internet web sites, and any other materials which contain statements about the benefit package, and provider-related network materials.	This requirement is to ensure that the MCO is complying with federal requirements, including marketing restrictions, accurate information (not false or misleading) and is not an inducement to enroll with the MCO.	Summary Data	Mandated by Contract	No	No	Yes	42 CFR §438.104	No
61	Human Services	PSD	MCO Stakeholder Group - Meeting Agendas and Minutes	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Biannually	Electronic	Our agreement with stakeholder groups through their involvement with the development of Special Needs Basic Care is that each MCO would maintain a local stakeholders group.	As an accountability measure under the contract withhold provision, DHS tracks the MCO's compliance with this requirement by having the MCOs submit minutes and meeting agendas describing the activities of the stakeholder groups and how the MCOs have responded to any concerns presented at the meetings.	Summary Data - Minutes and Agendas	Mandated by Contract	Yes	Minnesota Statutes §256B.69, subd. 28	No	No	No
62	Human Services	PSD	Additional Benefits and Premiums	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	This information identifies any additional benefits that may be offered through the Medicare Advantage Special Needs Plans bid process or premiums incurred through that process.	This annual information is needed for the State to: 1) know what benefits are being offered to the enrollees of the Medicare/Medicaid integrated programs, 2) avoid duplication of payments, and 3) identify additional costs that may have to be incurred by enrollees due to the Medicare premiums. The information is used for best practices and oversight of the Medicare/Medicaid integrated program.	Summary Data - Description Information	Mandated by Contract	No	No	No	No	No
63	Human Services	PSD	Sub contractual Delegation Report	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	Provide an annual schedule identifying subcontractors, their delegated functions and responsibilities and when the performance review of the subcontractor will be conducted.	The report is used for monitoring the MCO and their oversight of their delegates.	Individual Providers	Mandated by Contract	No	No	Yes	42 CFR §438.230	No

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64	Human Services	PSD	Deficit Reduction Act (DRA) Assurance Statement	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	This is a certification received from the MCO indicating its compliance in providing information and educating its employees, contractors, and agents on the False Claims Act (federal & state).	This is a report used to monitor MCO performance and compliance with the state and federal False Claims Act.	Summary Data - Certification	Mandated by Contract	Yes	Minnesota Statutes §15C.02	Yes	31 USC §§ 3729 through 3733 / §1902(aq)(68)(A) of the SSA	No
65	Human Services	PSD	Disclosure of Compliance with and Reporting of Physician Incentive Plans	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	MCOs report their compliance with federal requirements regarding incentive arrangements with subcontractors as it relates to risk.	The report is used to monitor MCO performance and compliance.	Summary Data - Certification	Mandated by Contract	No	No	Yes	42 CFR §417.79	No
66	Human Services	PSD	Waiver Obligation Process	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO is required to notify DHS when changes are made to their waiver obligation process or if no change is made by April 15th of the contract year.	DHS needs to have the MCOs indicate changes to their waiver obligation process so DHS can review those changes to confirm their process is still in compliance.	Summary Data - Description Information	Mandated by Contract	No	No	No	No	No
67	Human Services	PSD	Audit of Provider Compliance	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	MCOs are required to audit a sample of its providers by physician or clinic to determine provider compliance with preventive and chronic disease practice guidelines for children, adolescents, prenatal care, young adults and adult populations and to ensure that the guidelines are applied to decisions for utilization management, enrollee education, coverage of services, and other areas to which there is application and consistency with the guidelines.	This information is used for quality management reporting and is incorporated into the MCO's annual quality assessment and performance improvement program evaluation.	Individual Providers	Mandated by contract; can be submitted as part of Annual QA/PI Program Evaluation report (#23)	No	No	Yes	42 CFR §438.236	No
68	Human Services	PSD	Annual QA Work Plan	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCOs are required to provide to DHS an annual written work plan that details the MCO's proposed quality assurance and performance improvement projects for the contract year.	This work plan information is used in conjunction with the requirement that the MCO conduct an annual quality assessment and performance improvement program evaluation and is used to monitor the MCO's performance and compliance.	Summary Data - Work Plan	Mandated by Contract	Yes	Minnesota Rules , Part 4685.1130	Yes	42 CFR §438.240	No

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69	Human Services	PSD	Annual QA/PI Program Evaluation	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must conduct an annual quality assessment and performance improvement program evaluation to review the impact and effectiveness of the MCO's quality assessment and performance improvement program including performance on standardized measures and performance improvement projects.	The evaluation is used to monitor the MCO's performance and compliance.	Summary Data - Evaluation	Mandated by Contract	Yes	Minnesota Rules , Part 4685.1115	Yes	42 CFR §438.240	No
70	Human Services	PSD	MCO Disclosure of Ownership Information	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCO must report to DHS full disclosure information for each person or subcontractor that has an ownership or control interest in the MCO of 5% or more and whether any of the individuals is related to any other person with a ownership or control interest, including another disclosing entity with an ownership or control interest in the MCO.	The information is used to ensure that any person identified by the MCO is not excluded from participating in any federal program. DHS checks all of the identified persons against the LEIE (Lists of Excluded Individuals and Entities) and the EPLS (Excluded Parties List System) to be in compliance with the federal regulation.	Individual Data	Mandated by Contract	No	No	Yes	42 CFR §455.104	Yes - Private information is provided on individuals and is protected.
71	Human Services	PSD	Performance Improvement Project Reporting	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	MCOs propose a new project, annually update the report, and complete the report when the project is successful. MCOs may collaborate on a proposal and submit one report.	Reported information is used in the annual evaluation of the MCO's performance as required by federal regulation.	Summary	Mandated by Contract	No	No	Yes	42 CFR §438.240	No
72	Human Services	PSD	MCO Subcontractor Disclosure of Transactions and Ownership	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The MCOs provide a letter of assurance to DHS stating that the MCO has requested of all their subcontractors disclosure of ownership and control information and reviewed the information prior to contract renewal with the subcontractor.	To ensure that the MCO has complied with federal law and performed its due diligence in ensuring that any person identified by the subcontractor is not excluded from participating in any federal program. MCOs are required to check their subcontractors against the LEIE and EPLS.	Summary Data - Letter of Assurance	Mandated by Contract	No	No	Yes	42 CFR §455.104	Yes - Private information is provided on individuals and is protected.

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73	Human Services	PSD	Care Coordination Systems	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	N/A	This is a description of the entire care coordination system, the SNP Modal of Care, staffing ratios, lists of entities providing care coordination and case management, screening and assessment tools, timelines and follow-up processes, protocols for management of chronic conditions, procedures for communication with clinics and physicians, and training with subcontractors.	This is used for DHS' oversight of the 1915(c) waiver and for oversight of MCO's capacity to meet the special needs of the senior population.	Summary Data - Description Information	Mandated by Contract	No	No	Yes	42 CFR §438.208	No
74	Human Services	PSD	Care and Case Management Systems Changes	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	This is a description of the MCOs Special Needs Plan Model of Care and subcontractors involvement in providing care coordination and case management. This Model of Care is a CMS federal requirement under the MCO's separate contract for Medicare services.	DHS must request this model of care from the MCOs in order to understand what care coordination is required by Medicare and how it is being provided by the MCO SNP to the SNBC enrollees in order to coordinate Medicare benefits and avoid duplication of efforts.	Summary Date - Description Information	Mandated by Contract	No	No	Yes	42 CFR §422.101, 42 CFR §422.152, and the 1915(c) Waiver	No
75	Human Services	PSD	Care Plan, County Case Management and Care System Audit Reports and Protocols	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	These are summary reports of activities that the MCOs must conduct for oversight and compliance with DHS' 1915(c) waiver for seniors. The MCOs are also required to submit copies of the protocols used in the audit.	The individual care plan audit results, system-level subcontractor audit reports and the protocols are used by Continuing Care to meet the State's obligation to comply with CMS oversight requirements for Elderly Waiver services under the 1915(c) Waiver.	Summary Data - Reports	Mandated by Contract	No	No	Yes	42 CFR §422.101, 42 CFR §422.152, and the 1915(c) Waiver	No
76	Human Services	PSD	HOS Health Survey	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The Health Outcomes Survey is a federal Medicare requirement and is collected on enrollees in Medicare Advantage Special Needs Plans. This information describes the health status of these enrollees. Each MCO SNP receives a summary report based on the survey from CMS.	DHS requests a copy of this summary report in order to have information on the frailty status of MCO SNPs enrollees in integrated Medicare/Medicaid plans. [Copy is sent to DHS in lieu of other reporting.]	Summary Data - Survey	Mandated by Contract	No	No	No	No	No

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77	Human Services	PSD	Access Survey	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	This survey was developed by DHS and the MCOs in response to stakeholder's request for information on ADA accessibility of clinics and medical equipment.	The access survey was developed to provide information to people with disabilities about which providers are accessible for their health care needs when they have medical appointments.	Summary Data - Survey	Mandated by Contract	No	No	No	No	No
78	Human Services	AMH	CMHRS	Providers/Counties delivering Community Mental Health Service	No	Yes	No	No	No	Biannually	Electronic	Providers are required to report services provided.	Complete federal block grant requirements and state administration.	Individual-level	Mandated	Yes	State Statue 245 Compressive Mental Health Act	No	No	Yes
79	Human Services	CMH	Grant Reports	Grantees	No	Yes	Yes	No	County	Quarterly	Electronic	Grant expenditures and client outcomes.	Measure effectiveness of program. Complete federal block grant requirements.	Individual and Summary	Mandated	Yes	245.4889, Subd. 2	Yes	Title XIX, Part B, subpart 1, of the Public Health Services Act (Public Law 106-310, 42 U.S.C. 300X, and amendments thereto) Catalog of Federal Domestic Assistance (CFDA) No. 93.958.	Yes. Individual health information is protected under HIPAA.
80	Human Services and Health	PSD	Evidence of Coverage Review and Approval	Managed Care Organizations (MCOs)	No	No	No	Yes	No	Annually	Electronic	The Evidence of Coverage is an important document that is sent to enrollees as part of their enrollment materials that identifies the covered services, cost-sharing, grievance and appeal process, referral and authorization requirements, enrollee bill of rights and responsibilities, and services that are not covered. There is a Evidence of Coverage for each managed care program.	This document is required under state law and meets the requirements for enrollee information under federal law. As stated previously the document is part of enrollment materials that is sent to enrollees.	Summary Data	Mandated by Contract	Yes	Minnesota Statutes §62D.07	Yes	42 CFR §438.10	No